Maternal and Child Health Services
Title V Block Grant

State Narrative for Pennsylvania

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The appropriate Assurances and Certifications (non-construction program, debarment and suspension, drug free workplace, lobbying, program fraud, and tobacco smoke) are signed and on file in the Director's Office of the Bureau of Family Health. They can be obtained by calling (717) 787-7192.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Bureau of Family Health solicits meaningful public input through an ongoing process and via various mechanisms such as stakeholder meetings, ad hoc committees, advisory boards/committees, and parent forums.

Public notification was provided in the Pennsylvania Bulletin and the draft 2011 Maternal and Child Health Services Block Grant Application and 2009 Annual Report was made available on the Department of Health's website from June 30, 2010 through August 15, 2010. Over 200 emails and solicitations for public comment and input were sent to MCH stakeholders. In addition, stakeholders were invited to participate in the planning meetings with Bureau staff. A number of stakeholders attended internal meetings open to the public and these stakeholders provided valuable feedback to Bureau staff in the preparation of this application.

Routine mechanisms are in place to obtain input and feedback on MCH programs. The Bureau utilizes advisory groups and task forces to regularly advise on these programs. This year, the Bureau convened a MCH Needs and Capacity Assessment Stakeholder Advisory Committee to assist with the Needs and Capacity Assessment. This committee was comprised of approximately 30 individuals representing providers, local health departments, state agencies, state policy offices, consumers of service, family members, academia, health statistics and research. These various constituents represented the needs and concerns of the three populations served by Title V.

The following activities were specifically linked to the application process to solicit comments and provide input into the 2011 Application:
TBI Advisory Board
CSHCN Stakeholder Workgroup and Parent Forums
Newborn Technical Advisory Group
Web Posting
Public Notices

Mass Email outreach
Priority Setting Meeting open to all MCH Stakeholders
4 Public Comment meetings
Needs Assessment Findings Review Meeting open to all MCH Stakeholders
Meetings with County/Municipal Health Departments
Ad hoc committees

As indicated above, four public comment meetings were held in various regions of the state: March 24, 2010, Williamsport and Harrisburg; April 5, 2010 Pittsburgh; April 6, 2010 Norristown.

These public comment meetings were held earlier in the process in order to allow time for input to be included in the 2011 Application. A summary of the Public Comment meetings are included in this application as an Attachment. Full transcripts are available to the public upon request.

Also, included in this 2011 Application, is a detailed accounting of how the Bureau's Title V MCH Priorities were selected. The Bureau utilized a scientific and transparent process, open to all MCH stakeholders to select priorities. In this way, all stakeholders had meaningful roles in working with the Title V staff to identify these priorities through a consensus process. (Detailed in Section IV B)

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Bureau of Family Health, contracted with REDA International, Inc. in 2009-10 to conduct a five year statewide needs and capacity assessment of maternal, child and family health. The purpose of this assessment was to gather and present current information about the health and well being of the women, infants, children and children with special health care needs (CSHCN) residing in the Commonwealth. The assessment was conducted under the auspices of the Federal Title V Maternal and Child Health Program in accordance with the mandate to states to conduct an in depth maternal and child health needs and capacity assessment every five years. For the needs and capacity assessment the most current available secondary data were used to assess indicators of health status in the MCH population groups, with supplemental qualitative data obtained through primary sources. Primary sources of data included questionnaires and surveys, focus groups and key informant interviews.

The overarching methodological framework for the assessment was based on the participatory action research model. Participatory research is a collaborative approach that builds on the contributions of everyone involved, including program managers, recipient agencies, their clients, and other stakeholders. In the participatory action research model, the participating stakeholders are directly involved in designing and conducting the assessment. Unlike an independent assessment, the participatory approach involves ongoing, collaborative communication processes between stakeholders and researchers. The participatory approach ensures that the results of the assessment provide the Title V program managers and stakeholders with the most useful information about MCH needs and gaps in service provision, helping them formulate the next set of priorities.

A two-tiered approach for stakeholder involvement was used in the assessment process. Tier one was a core stakeholder group comprised of a limited number of entities that are familiar with the Title V program and with whom Title V works closely in support of services; they helped to advise the assessment process. This group functioned as an advisory group to the project. The second tier included a broader array of organizations, entities, and individuals with a vested interest in services for the MCH population, including non-traditional stakeholders, such as consumers, providers (both public and private), and academic researchers, whose feedback were solicited in a variety of ways, but primarily through scheduled key informant interviews. REDA also reached out to under-represented demographic groups (e.g., advocates for African Americans and Latinos), advocacy organizations and underserved geographic areas to give voice to these stakeholders.

For each population group (mothers, pregnant women, and infants under 1, children and adolescents, and CSHCN), REDA identified health risk factors and barriers to care. For mothers risks included: poor nutrition, lack of exercise, obesity, substance abuse, mental health problems, and illiteracy. For pregnant women the identified health risks included: substance abuse, nutrition, exercise and obesity, domestic violence, and mental health problems. For infants the identified health risks included: premature birth, maternal substance abuse, breastfeeding, Sudden Infant Death Syndrome (SIDS), and Abusive Head Trauma/Shaken Baby Syndrome. For children the identified health risk factors included: poor nutrition, lack of exercise, obesity, domestic violence, lack of preventive dental care, environmental hazards and safety hazards and injuries. For adolescents similar health risk factors were identified, however, there were some additional health risk factors that were reported in addition to those identified for children,

including: mental health problems, substance abuse, high risk sexual behaviors, and school violence. For CSHCN, the identified health risk factor was lack of access to care. For all population groups, barriers to care were explored in terms of affordability of services, availability of services, and access to services. In addition, for CSHCN quality of services was addressed as a barrier to care.

The capacity assessment addressed the Commonwealth's ability to provide direct, enabling, population-based and infrastructure building services to the MCH population. For direct care and enabling services, the following topics were identified as issues: financial barriers to health care and support services for MCH population; the impact of emerging issues on the Commonwealth's ability to provide direct health care services; assessment of the availability of services; health care provider shortages; linkages to promote the provision of services and referrals between primary, secondary, and tertiary care; underserved geographical areas; and priorities regarding access to health care and health-related services. Population-based services were identified by: programs and services directly managed by the Department of Health; other population-based programs provided by the Commonwealth for the MCH population groups; and coordination between the DOH and other agencies and organizations in the provision of population-based services. The infrastructure building component of the assessment explored: the structure of the public health system and mechanisms for provision of services; other key agencies and programming efforts; systems for CSHCN; coordination efforts related to MCH services; health care facilities available to the MCH population; health care providers; health care financing key to the MCH services system; and internal capacity using the CAST-V process. A full copy of the Needs and Capacity Assessment is included in this application as an attachment.

III. State Overview

A. Overview

In Pennsylvania, Title V dollars support county/municipal health departments, profit and non-profit organizations, universities, and community and tertiary hospital facilities in providing comprehensive adolescent health services, education and family support through home visiting programs, direct health services for children and children with special health care needs, information and referral services, primary and preventative care for children, teen pregnancy prevention programs, newborn hearing and metabolic screening and follow-up, lead poisoning prevention and testing, pediatric medical homes, needs and capacity assessments, outreach to children and their families, and postpartum depression services.

Geography

Pennsylvania is located in the Mid-Atlantic region of the United States. Pennsylvania has a land area of 44,817 square miles, placing it 33rd among the fifty states. It is comprised of 67 counties, 56 cities, and 962 boroughs. Forty-eight of Pennsylvania's 67 counties are classified as rural according to the Center for Rural Pennsylvania. Approximately 28% of the state's population live in the rural counties and 72% live in the state's 19 urban counties.

Government

Like the United States, Pennsylvania's government is defined by a constitution and is comprised of three equal and independent branches. The legislative branch makes commonwealth laws, a responsibility carried out by the General Assembly. The General Assembly consists of two bodies--the Senate (50 Senators) and the House of Representatives (203 representatives). The executive branch administers commonwealth laws and is overseen by the Governor. Finally, the judicial branch preserves the rule of law and guarantees citizens' rights by resolving disputes through the courts. The Governor's Office promulgates major program and priority changes. The budget for State Fiscal Year 2009-2010 was signed on October 9, 2009, 101 days after the start of the state fiscal year. Pennsylvania was the last state in the nation to have a signed budget. All States are currently facing one of the worst fiscal periods since the Great Depression and Pennsylvania is no different. Cost containment efforts in Pennsylvania include: 1) A general hiring freeze, followed by employee layoffs which reduced the state workforce by 4.8% between January 2003 and December 2009; 2) Out-of-state travel restrictions; 3) A ban on the purchase of new state vehicles (there are 500 fewer vehicles in the Commonwealth's fleet than last year); 4) A freeze on cabinet and non-union employees' salaries-they have not seen an increase since July 2008; and 5) Budget reductions. One hundred forty-two (142) of the 657 line items in last year's budget were completely eliminated this year. Another 360 line items were reduced. In addition to the reduced budget, on February 18, 2010 the Governor enacted another 1% reduction of all General Fund appropriations, reducing the budget again by $128,374,000. Pennsylvania is the only major industrial state in the nation found to be fiscally sound, ranking 7th in the nation for fiscal stability, tied with the much smaller state of Utah.

Population

Pennsylvania ranks 6th as the most populated State in the country with an estimated population of 12,604,767 people for 2009 (Pennsylvania State Data Center's Pennsylvania Facts 2010) and a population density of 281 persons per square mile. The population is diverse in geography, age, race, culture, and linguistic make up. The gender distribution is 51.3% female and 48.7% male. Of the state's 12.6 million residents, approximately 22.2% are under the age of 18; 62.5% are 18 to 64; 12.8% are 65 to 84; and 2.5% are 85 and older. Pennsylvania's population has the 3rd highest proportion of people 65 and older in the United States. The median age of Pennsylvania residents is 40 years of age.

Race and Ethnicity

Pennsylvania's largest minority groups are African-Americans, Hispanics and Asian-Pacific Islanders. African-Americans comprise 10.8% of the state's population, while the Hispanic group

which can span more than one racial category accounts for 4.8% and the Asian-Pacific Islanders account for 2.4%. Since 1991, refugees from over thirty countries have resettled in the Commonwealth, representing diverse ethnic, cultural and religious backgrounds. According to the Pennsylvania Refugee Resettlement Program, 2,203 refugees resettled in Pennsylvania between October 2008 and September 2009. Most were from Bhutan (785), Burma (456) and Iraq (416). The mission of the Refugee Resettlement Program is to help refugees and their families obtain employment, economic self-sufficiency and social integration within the shortest possible time after their arrival into the Commonwealth. Some of the services we provide to these multicultural immigrants include: 1) Special Supplemental Nutritional Program for Women, Infants and Children; 2) newborn screening and follow-up for metabolic conditions; and 3) genetic counseling.

Income

According to the Economic Outlook for 2010-11 in the Governor's Budget Address, Personal income growth experienced annual declines in 2008 and 2009, declining 0.4 percent and 1.6 percent, respectively. Despite rising unemployment, growth in real personal income is expected to rebound in 2010, growing 1.7 percent annually. Stronger personal income growth is forecast from 2011 through 2013 as unemployment eases. The Commonwealth's economic performance is largely dependent upon job growth. Since December 2007 and the start of the national recession, Pennsylvania has lost more than 212,000 jobs. In December 2009, the commonwealth's unemployment rate was 8.9 percent, its highest level since August 1984. The national unemployment rate for December 2009 was 10 percent. Pennsylvania's unemployment rate has now been equal to or below the national average for 83 of the past 84 months.

The inverse relationship of the U.S. and the commonwealth growth in personal income has re-emerged during the current recession. As the current recession has deepened, the rate of growth in real personal income plunged for the nation as a whole, as it did for the commonwealth. However, the decline in the rate of growth was less severe for Pennsylvania than for the rest of the nation. In fact, the commonwealth ranked 12th in the nation in terms of the percent change in personal income during 2008. Economists expect that the rate of growth in Pennsylvania real personal income will exceed the national average in 2011 and 2012. This strong performance is partially the result of the diversification of the Pennsylvania economy and a stronger state labor market. The growth of less recession-prone industries such as health care, pharmaceuticals, education and government has aided the commonwealth.

The short-term outlook for Pennsylvania is that its economy remains heavily dependent on the national economy. The commonwealth actually outperformed the national economy during 2008, growing at an annual rate of 1.1 percent while the national economy grew at a rate of only 0.4 percent. Similarly, during 2009, the state economy again outperformed the national economy by recording a lower loss -- negative 2.0 percent for the commonwealth versus negative 2.5 percent for the broader U.S. economy. Beginning in 2010 through 2012, the gap between the two rates of growth is expected to re-emerge as the national economy expands.

Employment

Since peaking in December 2007, nearly eight million jobs have been lost nationally. Job losses, declines in household wealth and tighter credit are just a few of the factors adversely affecting consumer spending. The unemployment rate in Pennsylvania is 9.1 percent, and the average unemployment check in Pennsylvania is approximately $310.

Pennsylvania's fiscal year 2009 job losses were lower than the national average, and remained less steep than those of the surrounding states of New Jersey, Delaware and Ohio. Further, among the ten largest states, only Texas, New York and Pennsylvania lost jobs at rates lower than the national average.

Employment in the commonwealth saw job losses across all sectors in 2009 except for the educational and health services sectors -- which had job growth of 2.0 percent in 2009 and the

government sector -- which had job growth of 0.1 percent in 2009. The manufacturing and information technology sectors had the worst year-over-year rate of job losses in 2009, with manufacturing jobs down 10.3 percent and information technology jobs down 6.6 percent. The construction, natural resources and mining; financial services; and professional and business services sectors also saw significant job losses in 2009, with each sector experiencing year-over-year job losses in excess of 5.4 percent.

The Pennsylvania Unemployment Rate for March 2010 rose from 8.9 percent to 9 percent, according to the Pennsylvania Department of Labor & Industry. The rate was up 1.5 percentage points from March 2009. The national unemployment rate is 9.7 percent. In February, the most recent month for which national figures have been released, the rate was 9.8 percent.

The annual change in employment levels in Pennsylvania is forecast at around -0.4 percent in 2010, while positive job growth is expected to return in 2011 at a rate of 1.5 percent annually. Slightly more robust job growth is forecast for the commonwealth in 2012, with job growth forecast at 2.2 percent. As the national economy begins to recover in 2010, the rate of job growth in Pennsylvania is expected to again lag behind the national average. Total job losses for the Commonwealth are expected to reach 231,000.

Housing
The United States housing bubble had an economic affect on the housing market in almost every state. A decline in housing construction and housing finance has, in part, led the economy into a recession. Until the housing markets stabilize, any recovery will be uneven. For all of 2010, residential construction is expected to grow just 5.8% on an annual basis. Further, sales of existing homes rose in 2009 for the first time in four years. Still, median existing housing prices plunged more than 12% last year. Overall median existing housing prices are expected to continue to grow minimally in 2010 and 2011, at annual rates of 1.3% and 1.2%, respectively. Pennsylvania has a balanced economy based on government, higher education and healthcare. The construction industry in Pennsylvania is stronger and unemployment is lower than the national rate. Pennsylvania did not have the housing boom or as much speculation, therefore it was not affected as severely as most other states. Continuing threats to the housing crisis are unemployment, elevated vacancy rates, record foreclosures and the end of the homebuyer tax credit.

B. Agency Capacity

The Bureau of Family Health, as the State Title V Agency in Pennsylvania promotes and protects the health of pregnant women, infants, children and children with special health care needs, through education, health promotion, treatment services, food benefits and access to health care. Every day, the Bureau strives to improve the health care and nutritional needs of Pennsylvania families. The Bureau, through its Division of Child and Adult Health Services, Newborn Screening and Genetics, Community Systems Development and Outreach, Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Operations, demonstrates capacity to promote and protect the health of all mothers and children, including children with special health care needs, through a variety of direct health care, population based, and enabling services.

The Division of Child and Adult Health Services

The Division of Child and Adult Health Services is responsible for many facets of maternal, child and infant health, from building and sustaining infrastructure to the provision of direct health services, population based services and enabling services. Title V dollars are used to support a variety of efforts including: reducing and eliminating infant mortality and the racial and ethnic disparities associated with these deaths, childhood lead poisoning prevention, family planning, teen pregnancy prevention, home visitation programs for pregnant and postpartum women, prevention of shaken baby syndrome, SIDS and infants deaths caused by suffocation or

strangulation resulting from unsafe sleep practices, primary and preventative care services for infants and children, case coordination and case management for children with special health care needs, child death reviews, school re-entry for children and adolescents impacted by traumatic brain injury, and prenatal care for uninsured women.

Despite consistent programming, there remain significant concerns such as infant mortality, low birth weight babies, teen pregnancy, children who are lead poisoned, high risk adolescents who do not have a primary care physician, a medical home, or a place where they feel safe getting health care, and children who lack health insurance. Many of these health status indicators demonstrate significant health disparities. For example, in 2008, the state rate of infant mortality (per 1000 live births) was 7.3 for all births. However, the rate for black infants was 14.4 per 1000 live births. The overall percentage of women receiving prenatal care in the 1st trimester in 2008 was 79.4% while the percent of African American women was 64.1% and 67.2% for Hispanic women. For teens, in 2008, the rate of pregnancy for 15-17 year olds in Pennsylvania was 24.4 per 1,000; however, for African American and Latina teens, the rates were significantly higher (75.5 and 66.2 respectively).

One new model that the DCAHS will be working with all vendors to implement is the evidence-based Life Course Model. The Life Course Health Development Model emphasizes that early experiences, including both risk and protective factors, affect later health. To be a bit more specific, the model suggests that the interplay of biological, behavioral, psychological and social protective and risk factors contribute to health outcomes across the span of a person's life. So, for example, disparities in birth outcomes such as low birth weight, and infant mortality are often explained by the quality and frequency of prenatal care. In contrast, the Life Course Model suggests that these disparities result from differences in protective and risk factors between groups of women over the course of their lives. As a result, the health and socioeconomic status of one generation directly affects that health status of the next one. Examples of Protective and Risk Factors include: SES, race and racism, health care, disease status, stress, nutrition, weight status, birth weight, education, and housing. There is also a concept known as "weathering" which refers to life events that wear and tear on a person over time. "Weathering" is also a risk factor. It is widely accepted that over the course of a women's reproductive course, African American women have far more risk factors, and far few protective factors and these are correlated linearly with birth outcomes.

In addition to the Maternal and Child Health Services Block Grant, the DCAHS is also responsible for the administration of several other federal grants including: Housing and Urban Development Lead Hazard Control Program and the Healthy Homes Program; Centers for Disease Control and Prevention Childhood Lead Poisoning Prevention and the Pregnancy Risk Assessment Monitoring Systems; Health Resources and Services Administration Traumatic Brain Injury State Grants Program, Implementation Partnership Grant.

The Division of Community Systems Development and Outreach

The Division is responsible for several initiatives within the Bureau. These include the State Lead Program, grants providing education and advocacy on epilepsy and Tourette Syndrome, increasing breastfeeding initiation and duration rates, and a major focus on children and youth with special health care needs through such efforts as the Special Kids Network helpline at the Health and Human Services Call Center, the Special Kids Network System of Care Program, implementing a State Implementation Grant for Integrated Services for Children with Special Health Care Needs (SIG), and building the state's capacity for pediatric medical homes.

A guiding factor for the Division over the past years has been the previous work of the Children with Special Health Care Needs Stakeholder Group Recommendations. This diverse group of individuals came together at the request of the Department to generate recommendations that would give direction for improving services for children with special health care needs and their families. Since that time, the Division has made strides in addressing each of the key focus areas

recommended for action by the group. Data involves providing meaningful information to support funding, programmatic and policy decisions; transition through adulthood; screening for special health care needs early and continuously; family centered care approach to involve families and youth in planning, delivery and evaluation; and home visiting for low income women at risk for poor birth outcomes. Activities in these key focus areas have been woven throughout the work of the Division and reflected within the National Performance Measures that address children with special health care needs (2, 3, 5 & 6).

The State Lead Program resides in the Division of Community Systems Development and Outreach. The program provides free lead abatement training at the Lead Abatement Training Center in Danville, PA, to all non-profit and government employees in the Commonwealth. The program conducts outreach events to promote the dangers of childhood lead poisoning and safe and accepted work practices for lead abatement and renovation work. The program also provides oversight of the toll-free Lead Information Line, which is responsible for the dissemination of information on lead paint dangers and poisoning prevention, as well as accepted safe work practices. Information is provided via telephone and website. The program is funded by the Environmental Protection Agency and is not Title V Block Grant funded.

The Special Kids Network System of Care program works to address barriers and challenges families experience when trying to secure services for their children or in just trying to help their children lead full, productive and healthy lives. Department of Health employees, called Family Health Nursing Services Consultants, are located throughout Pennsylvania and provide the support for the activities of the Special Kids Network System of Care program. System of Care focuses on four main components: Community Systems Development (creation or enhancement of services); Community Mapping (developing a strength and gap analysis of communities regarding CYSHCN); Statewide Initiatives (addressing issues pertinent to most or all CYSHCN) and Outreach (building awareness and support for program goals). The System of Care web portal provides yet another source of information and resources for parents of CYSHCN, advising them of events and service providers available in their communities, and providing links to other organizations and programs.

Families of children and youth with special health care needs in Pennsylvania continue to express the need for access to services and comprehensive information. In a continued response to this need, the Division of Community Systems Development and Outreach has supported the "one call "concept for information and referrals through the Health and Human Services Call Center (HHSCC) since 2004. Four of the ten helplines (Healthy Baby, Healthy Kids, Special Kids Network and Recreation & Leisure) are funded by the Maternal and Child Health Block Grant (MCHBG), as is the System of Care helpline and web portal, which was recently added through the support of the contractor. Callers can obtain information about caring for their baby, applying for Medical Assistance or other insurance, and locate assistance for a child with a special need all on the same call. The Call Center continues to expand the number of resources in its resource database, has a web presence and recently added a live email chat feature and the HelpinPA facebook page, providing new ways in which families can reach out for assistance. During the past fiscal year, the call center has provided 8,572 live chats through its website, and between May 1, 2010 and June 21, 2010, the call center has accumulated 275 fans on its facebook page.

The HHSCC has bilingual staff serving Spanish and Russian language callers, and has had access to 100 additional languages through interpretation services. A change to a new provider, Propio, for language services is hoped to provide better, faster access and opportunities for translation of fulfillment documents into languages other than Spanish. General program and health information materials are available in English and Spanish. Currently there is only one major fulfillment document translated to Chinese, the Healthy Baby booklet, which is a comprehensive guide for pregnant women and parents of infants. Outreach activities are conducted by HHSCC staff in diverse communities to promote awareness of HHSCC services.

Pennsylvania's EPIC BEST Initiative (Educating Physicians in their Community Breastfeeding

Support and Training) began in January 2009 following a year of planning, program research, and recruitment of trainers for the project which educated 50 physician practices in the Southeast and Southwestern areas of the state. The strategy was to increase the number of health care professionals who promote breastfeeding by providing evidence-based education, assistance, support, and community referrals to women who were pregnant. The funds that supported the project were from the Prevention Block Grant, an example of how our Bureau works collaboratively within the Department.

Combined efforts under the State Implementation Grant have been designed to ensure that the Bureau becomes more family focused and engaged in meaningful partnerships with family and youth. A Parent Coordinator (parent of a child with special health care needs) was hired to convene a planning committee to generate ideas, build consensus and design a kickoff Consortium for CYSHCN conference. The work of the Consortium resulted in the implementation of regional parent, youth, and professional forums in six health districts in Pennsylvania. Key priorities identified by the forums were: access to community resources, increasing the number of medical homes, and transition to adulthood. Four parents of CYSHCN are engaged in comprehensive leadership training implemented by the Parent Education and Advocacy Leadership Center (PEAL). Once trained, the parents will assume leadership positions in the regional forums. To ensure that the service delivery and planning process is inclusive, we are conducting targeted outreach to families in communities with a large population of minorities and other cultural/ethnic groups that are under-represented at forum meetings. The youth voice is equally important in this process and a Youth Coordinator (young adult with special needs) was hired and continues to lead youth activities including, convening Youth Development Leadership Institute's across the state to engage youth with special health care needs in leadership training.

One Delaware County educational health program that is influencing women of all ages is the new moms/new parents project for the First Time Motherhood Grant. The new moms/new parents project is the only grant of this type in the state and one of only 13 awarded nationwide. The funding covers a two year period through August 2010. Activities are targeted to low income women of reproductive age living in Delaware County with special emphasis on pregnant women under 20, women of color, Hispanics and immigrants, women whose pregnancies were unintended, and women receiving Medicaid. The goal is to educate and empower women through health awareness. The program focuses on several key areas related to female health: nutrition, exercise, mental health, stress management, folic acid and safe relationships/sexual health. Promotional efforts include a comprehensive website, social networking sites, presentations at local schools and community organizations.

Staff represents the Secretary of Health on the PA Developmental Disabilities Council. The Council embraces a vision of a Commonwealth comprised of inclusive communities where all people with disabilities are valued and thrive. The Secretaries of Education, Public Welfare, Aging and Labor and Industry are also represented on this council and all agencies coordinate their efforts in assisting the Council in directional planning and oversight of the grants it issues. The Council supported 77 grant activities during calendar year 2009, ranging from grassroots demonstrations to statewide systems change grants. The Council also produces position and discussion papers, which are made available to the public on its website and through dissemination to stakeholders, as well as submission of critical issues to the Governor. Currently on the site are papers on Emergency Preparedness and Response, Cultural Competence, Voting, Inclusive Education, Employment, Criminal Justice, and Personal Care Homes. A new initiative during the current year will bring Council staff together with the Bureau of Family Health's Family Health Nursing Services Consultants, to connect the Consultants with community-based Council grantees that serve common populations. This will create the potential to connect individuals to services funded by Council grants, expand the Special Kids Network and System of Care provider network, and lay the groundwork for increased diversity in the Consultants' service delivery.

The Division of Newborn Screening and Genetics

The Division, which is comprised of the Newborn Screening, Newborn Hearing Screening, and Genetic Services Sections, has undergone some key changes during the past year. The Newborn Screening Section added 22 conditions to the list for which follow-up is provided to total 28 metabolic and genetic conditions. The Bureau purchased and is proceeding with development and implementation of a state-of-the-art integrated newborn metabolic and hearing screening tracking and follow-up database from OZ Systems, which utilizes HL7 messaging. This system will increase efficiency and reduce cost of program operation by facilitating secure electronic case management and communications with providers. The Genetic Services Section has an on-going challenge to assure access to services statewide with a budget of $300,000. Historically, grants were awarded to providers based on the highly specialized services they provided. This translated into concentrating money in the Philadelphia and Pittsburgh areas due to the existence of large medical research facilities. The field of genetics has expanded in recent years increasing the availability of services. To more equitably distribute funds, six grant opportunities are being made available. One grant will be offered in each of the six Pennsylvania districts.

Advances in the hearing screening program are enabling the Division to embrace the medical home concept for its clients. The Infant Hearing Education, Assessment, Reporting and Referral (IHEARR) Act (Act 89 of 2001) empowers the Department to administer a statewide comprehensive newborn hearing screening and follow-up program. The Division is interested in identifying the means to link infants to medical homes soon after discharge from their birth to enable the ideal primary care physicians to actively participate in direct care and follow-up. All of the state's 107 birthing hospitals report hearing screening results to the Division and refer failed screenings for follow-up tracking. Early Hearing Detection and Intervention (EHDI) Program data reveal that approximately 97.2% of all hospital births in 2008 completed a hearing screening. The PA EHDI Program reviews monthly hospital hearing screening performance numbers and, through a contract with the PA Chapter of the American Academy of Pediatrics, offers identified hospitals technical assistance in an effort to improve hearing screening performance.

State law currently mandates the screening and follow-up for six metabolic/genetic conditions: Congenital adrenal hyperplasia, Galactosemia, Hemoglobin diseases, Maple syrup urine disease, Phenylketonuria and Primary Congenital Hypothyroidism. The Newborn Child Testing Act (as amended by Act 36 of 2008, effective July 1, 2009), requires the Newborn Screening and Follow-Up Program to provide follow-up services related to case management, referrals, confirmatory testing, assessment and diagnosis for an additional 22 metabolic and genetic conditions to include Acylcarnitines, Amino Acids, Biotinidase and Cystic Fibrosis. All Pennsylvania hospitals offering maternity services now provide expanded screening.

The MCHSBG funds screening for all newborns and provides follow-up services to infants and children diagnosed with any of 28 tested metabolic conditions. Collaborative efforts are targeted to hospitals, metabolic disease treatment centers, other specialty centers, a host of medical and allied health providers, laboratories, and others. The Division presently offers early education for newborn screening prior to childbirth. The Division contracts for follow-up and case management with four Metabolic Disease Treatment Centers, and 10 University and Community Centers for Sickle Cell Disease.

During the past year, the Division contracted with a medical consultant to provide assistance and guidance in the follow up process. One project reaching conclusion is the development of an algorithm for each of the expanded screening conditions detailing follow-up workflow. Representatives of the Technical Advisory Board participated in the development of these documents and the full Board will review and approve them prior to implementation. Representatives of the Board are multi-disciplinary and are comprised of medical experts and representatives of groups with knowledge and interest in newborn screening.

The NSFP administers a statewide metabolic pharmacy formula program that enables clients with PKU to obtain metabolic formula at a pharmacy of their designation. Financial coverage for the

formula program has broadened for those clients receiving medical assistance.

The Division's genetic screening and counseling program ensures that eligible, low-income individuals and families seeking information about the occurrence, or risk of occurrence, of a genetic condition or birth defect are provided access to services. The Division issues grants to support comprehensive genetic screening centers and major metabolic screening and treatment centers. The hospital affiliated genetic screening centers' services include: explanation of the disorder(s) in question and associated problems; an examination of the family genetic history; research of the genetic condition; estimation of risk to family members and progeny; education on treatment and reproductive options; and referrals and follow-up for other services. The Genetics Program collaborates with seven comprehensive genetic screening centers and three major metabolic screening and treatment centers that function as part of newborn screening diagnosis treatment and case management services.

The Division coordinates multidisciplinary team clinics across the state to serve children and adults with special health care needs. The clinics provide professional expertise to improve systems of specialty care by coupling acute, chronic, and preventive medical care services with social and psycho-social care. Agreements are maintained with local medical and ancillary care providers to assure availability and accessibility to care other than in a tertiary center. The Commonwealth supports services for spina bifida, adult cystic fibrosis, Cooley's anemia, hemophilia and home services for children who are ventilator dependent. One-stop multidisciplinary team clinic visits afford patients a full gamut of necessary services to manage complex medical conditions. Services include specialized physician and surgical care, nutrition, case management, laboratory, radiology, pharmacology, speech therapy, physical therapy, occupational therapy, orthotic care, dental care and health education. These specialty services are delivered in a comprehensive, multidisciplinary manner using a team approach. The Division seeks to integrate children with metabolic and genetic conditions into medical homes that provide specialty care to adults and children.

The Division administers the Sickle Cell Disease (SCD) Program which provides medical and psycho-social services to children and adults statewide. Persons diagnosed with sickle cell disease and their families may receive care and services. Grantees include: four university-based hospital grantees that provide comprehensive medical care and psycho-social services to children and adults via a multidisciplinary team approach, and six community-based grantees that provide outreach, education and psycho-social services to patients and their families as well as the community at large. These providers employ the Medical Home concept to coordinate care and services to optimize patient outcomes. They work collaboratively to create a statewide presence and act as consultants to each other and to other health care professionals regarding the care and treatment of persons with Sickle Cell disease.

In 2009, the Division was awarded a grant from the National Center on Birth Defects and Developmental Disabilities of the Centers for Disease Control and Prevention for a Population-based Surveillance for Hemoglobinopathies Project (RuSH). The proposed work includes formation of a consortium to facilitate outreach across the state to identify, assess and analyze data on patients with hemoglobinopathies. The Division received $534,056 per year for two years. The RuSH grant is a multi-phase project in which six states work together with CDC to assess availability of data, develop new data sources, and design a data collection and reporting surveillance system that will ultimately become a national registry for patients with sickle cell disease and Thalassemia. The work done through this grant will be the cornerstone for Pennsylvania to develop its own sickle cell registry, and be part of an integrated electronic information database that can be accessed by medical providers resulting in improved care to patients.

The Division of Women, Infants and Children (WIC)

The Division of WIC administers the Special Supplemental Nutrition Program for Women, Infants

and Children in Pennsylvania. The Program provides supplemental nutritious foods, nutrition assessment, counseling and education, overweight and obesity prevention counseling, breastfeeding promotion and support, prenatal and pediatric health care referrals, immunization screening and drug and alcohol abuse referrals to women who are either pregnant or up to one year postpartum, infants and children up to the age of five. Although the WIC Program is funded by the USDA, it serves the Title V eligible population with income eligibility capped at 185% of the federal poverty level.

The WIC program provides services in all 67 Pennsylvania counties through 24 private non-profit or governmental WIC Local Agencies who provide services in a defined geographic area. These local agencies operate 334 WIC clinics in strategic locations throughout the state. In order to determine program eligibility these WIC clinics conduct a medical and dietary evaluation to determine nutritional risk, evaluate income sources to determine income eligibility and conduct in depth interviews with participants to determine what referrals would be appropriate.

The economic recession increased the demand for services as WIC saw program participation grow to 267,301 in November 2009. This was a 2.7% increase from 260,107 participants a year earlier. In 2009 the WIC program implemented the most sweeping changes to its food packages provided to WIC participants since the inception of the program. These changes include the introduction of fruits and vegetables, infant foods and whole grains to the program offerings. The program has undergone major changes in its nutrition service delivery techniques through the implementation of the Value Enhanced Nutrition Assessment (VENA) and guided goal setting.

The USDA Peer Counselor Program grant was increased which allowed PA WIC to expand this service. Four more agencies submitted proposals and have received initial training to implement the Peer Counseling Program and currently existing programs proposed to expand the number and/or hours of their peer counselors. There are now a total of ten local agencies with Peer Counselor Programs. Additionally, in efforts to increase the duration of breastfeeding, the WIC Program increased the amount of funding for breast pumps by 38% from $454,400 in federal fiscal year 2009 to $628,289 in federal fiscal year 2010.

The Division of WIC has taken an active role in the fight against food insecurity. The Division Director participated in a meeting with the Governor's Office and US Representative Robert Brady's Office to develop a strategy to combat hunger in the 1st Congressional District which in a recent survey ranked second in the nation in food insecurity.

The Division of Bureau Operations

The Division of Bureau Operations is a non-programmatic Division charged with managing and directing the Bureau of Family Health operations and administrative functions. This includes budgeting, procurement, information technology, equipment and human resources. This also includes the Bureau of Family Health's training efforts related to confidentiality, privacy and security requirements imposed by state and federal law, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) passed as part of the American Recovery and Reinvestment Act of 2009. The Division of Bureau Operations also conducted training on the newly implemented policies and procedures regarding the Commonwealth's Right to Know Law (RTKL) which was enacted on January 1, 2009. This Division also assists in the reproduction and dissemination of the MCHSBG Annual Report and Application.

Rehabilitative Services for Blind and Disabled Individuals

Although the Department of Health is not the agency responsible for the provision of rehabilitation services for blind and disabled children under age 16, the Department of Labor and Industry provides blind and visual services for children throughout the Commonwealth via professional staff in District Offices located in Altoona, Erie, Philadelphia, Harrisburg, Pittsburgh, and Wilkes-

Barre. Services include: counseling; advocacy for educational services; transition services; guidance and counseling for children and their families; community orientation and mobility instruction; children's summer programs; rehabilitation teaching; adaptive equipment; and, low vision services. Financial and visual eligibility is established before goods and services are purchased for the child.

An attachment is included in this section.

C. Organizational Structure

Edward G. Rendell was inaugurated as the Commonwealth of Pennsylvania's 45th Governor on January 21, 2003. The Governor serves as Chief Executive of the nation's 6th most populous state. The Governor's Cabinet is comprised of senior staff, Agency Heads and Deputy Secretaries. Each Secretary is responsible for the oversight of his or her agency. An equally important responsibility of all Cabinet members is advising the Governor on subjects related to their respective agencies. In 2007, Edward G. Rendell was elected another four year term. Please see attached file for Department of Health Organization Chart. On September 26, 2008, the Governor named Everette James, J.D., M.B.A., to serve as Secretary for the Department of Health. In this position the Secretary serves as the primary public health advocate and spokesman for Pennsylvania. As Pennsylvania's top health regulator, Secretary James is responsible for carrying out the Health Department's mission. Prior to his appointment as Secretary of Health, he served as a senior advisor to the Governor. He advised the Governor on health care and pension issues affecting the Commonwealth. James served as the Governor's senior staff liaison to the Departments of Health, Welfare, Insurance and Aging. He also served as a Trustee of the Public Employee Benefits Trust Fund and was the Governor's designee to the Boards of the Ben Franklin Technology Development Authority and the Public School Employees' Retirement System.

The mission of the Pennsylvania Department of Health is to: 1) promote healthy lifestyles; 2) prevent injury and disease; 3) ensure the safe delivery of quality health care services for all Pennsylvanians; and 4) eliminate health disparities. This mission is reflected in the Department's core functions identified as assessing health needs, developing resources, ensuring access to health care, promoting health and disease prevention, ensuring quality, and providing leadership in the area of health planning and policy development. The core functions of the DOH are carried out by four Deputy Secretaries; 1) Health Planning and Assessment; 2) Quality Assurance; 3) Health Promotion and Disease Prevention; and 4) Administration. Bureaus housed within these Offices that play a significant role in program administration and service delivery to the maternal and child population are highlighted under its corresponding Office.

Many of Pennsylvania's public health personnel are concentrated in the 10 municipal and county health departments. In Pennsylvania, public health workers are employed by the State and county/municipal health departments. In relation to its population, Pennsylvania has the lowest number of public health personnel of any State, with only 37 professionals per 100,000 residents, which is less than one-third of the national average. The most significant shortage is public health nurses, who account for about 15 percent of the public health work force.

The Department of Health oversees health services administered to residents of Pennsylvania's 67 counties through a system of 6 community health districts, 60 State Health Centers and 10 county and municipal health departments though the Bureau of Community Health Systems, represented in the MCH needs analysis. The six community health districts have the following geographic designations: Northwest, North-central, Northeast, Southwest, South-central, and Southeast.

The Deputate of Health Promotion and Disease Prevention has responsibility for developing and implementing a wide variety of education, preventative, and treatment programs including, but not limited to the areas of communicable diseases; family health, including infant nutrition programs;

cancer; HIV/AIDS; and tobacco, drug, and alcohol abuse. The Bureau of Family Health is responsible for the administration of Title V programs.

An attachment is included in this section.

D. Other MCH Capacity

The Bureau of Family Health, through its Divisions of Child and Adult Health Services (CAHS), Community Systems Development and Outreach (CSDO), Newborn Screening and Genetics (NSG), and Special Supplemental Nutrition Program for Women Infants and Children (WIC) exercises its capacity to promote and protect the health of all mothers and children, including children with special health care needs (CSHCN), through a variety of services. The following are the Title V funded positions.

PA Department of Health -- Departmental Title V Funded Staff for Calendar Year 2009.
Program - Number of Funded Personnel - Location
Bureau of Family Health
BFH Bureau Office - 2 - Harrisburg, PA
Bureau Operations - 4 - Harrisburg, PA
Child and Adult Health Services - 16 - Harrisburg, PA
Community Systems Development & Outreach - 12 - Harrisburg, PA
Newborn Screening and Genetics - 20 - Harrisburg, PA
Other DOH Offices
Community Health Systems -School Health - 2 - Harrisburg, PA
Community Health Systems-MCH & SHCN Nurses - 12 - Statewide
Bureau of Laboratories - 2 - Lionville, PA
Bureau of Information Technology - 1 - Harrisburg, PA
Office of Legal Counsel - 1 - Harrisburg, PA
Bureau of Health Risk Reduction - 1 - Harrisburg, PA
TOTAL - 73

Bureau of Family Health -- Director: Melita Jordan, CNM, MSN, APRN C
Ms. Jordan has served in her current capacity as Director of the Bureau of Family Health since September 2004. She has more than two decades of experience in the field of maternal child health. Previously she served as Director of Women's Services and Director of Nurse-Midwifery Services at Mercy Hospital of Philadelphia. From 1988 to 1990, she served as Chair of the Mayor's Commission for Women's Health Task Force for the City of Philadelphia. She graduated from Seton Hall University with a B.S. in Nursing and received her Master of Nursing Science from the University of Medicine and Dentistry of New Jersey. She serves as an Adjunct Faculty member at Drexel University School of Public Health Doctorial and Executive MPH Program as well as the MCH Director for the Commonwealth.

Bureau of Family Health -- Director of the Division of Bureau Operations: Robin Cohick
Ms. Cohick assumed the responsibilities of Director of the Division of Bureau Operations on July 7, 2008. Before coming to the Bureau of Family Health, Ms. Cohick was the Chief Grants and Fiscal Administrator in the Bureau of Health Statistics and Research. She has twenty-five years of service in the Department of Health working in several other Bureaus.

Bureau of Family Health-Director of the Division of Child and Adult Health Services: Carolyn Cass, Ph.D.
Ms. Cass has worked in the field of public health since 1997. Prior to that, she worked in the field of behavioral health for over 15 years, primarily providing drug and alcohol treatment services for adolescents and individuals in the state hospital system. Ms. Cass has served as adjunct faculty at West Chester University since 1994 and has served on the faculty at Temple University as well.

Bureau of Family Health-Director of the Division of Community Systems Development and Outreach: Michelle Connors
Ms. Connors has served in the field of Public Health for over 20 years. She came to the Department in 1989 and has served as the state's Title V Children with Special Health Care Needs Director since 2002. Ms. Connors holds a Bachelor's Degree from Pennsylvania State University and her Division manages a variety of programs that focus on children with disabilities.

Bureau of Family Health-Director of the Division of Newborn Screening and Genetics: William Cramer
Mr. Cramer has worked in the public health field for the past 10 years. He assumed the position of Director of Newborn Screening and Genetics on January 1, 2010. Prior to his appointment, he worked as the Director of Healthcare Associated Infection (HAI) where he was responsible for the development and implementation of statewide HAI reporting in the Department's Office of Quality Assurance. He has also held the position of Health Facility Quality Examiner (HFQE) as well as Complaint and Investigation Supervisor in Quality Assurance's Division of Nursing Care Facilities. During his first 10 years of state employment, he worked in the correctional system as a Drug and Alcohol Treatment Specialist and Supervisor. He has a Master's of Education from Penn State University and a Bachelor's from Indiana University of PA.

Bureau of Family Health-Director of the Division of WIC: Gregory Landis
Mr. Landis has been with the WIC Program since July 1988, first as Chief of the Grants and Retail Store Management Section and in May 2007 he assumed the role of Director.

Bureau of Community Health Systems, Acting Director: Jeffrey A. Blystone
Mr. Blystone is the Acting Director of the Bureau of Community Health Systems. He is responsible for directing the provision of numerous public health services that includes health promotion and education, immunization, and the monitoring, tracking and control of communicable diseases to the citizens of the Commonwealth. Additionally, he oversees the coordination of similar programs within six (6) county and four (4) municipal health departments and collaborates with other state and community agencies, professional groups, and community organizations.

Bureau of Community Health Systems- Acting Director of the Division of School Health: Beth Bahn
Ms. Bahn is the Acting Director, Division of School Health. Ms. Bahn has been with the Division as a State School Health Consultant since 2005. Her prior experience includes: 12 years with the Red Lion Area School District as a Certified School Nurse, the last 3 years as a Certified Registered Nurse Practitioner; and 12 years as a Charge Nurse with York Hospital. She is a Founding member of Pennsylvania Association of School Nurses and Practitioners and has served 12 years on their Board of Directors.

Bureau of Health Promotion and Risk Reduction, Director: Leslie Best
Ms. Best is the Director of the Bureau of Health Promotion and Risk Reduction overseeing statewide planning and implementation of health promotion and disease prevention programs. The BHPRR addresses heart disease and stroke, cancer, arthritis, diabetes, tobacco prevention and cessation, oral health, physical activity, and health education services. Employees in this Bureau have Title V responsibilities include Stewart Williams, Violence & Injury Prevention Program Administrator. Mr. Williams is responsible for the Childhood Injury Prevention Program (CIPP). Howard Tolchinsky, DMD, State Public Health Dentist, is responsible for the Oral Health Program. The mission of the Oral Health Program is to promote good oral health as an integral part of the well-being of all Pennsylvania citizens, reinforcing the concept that you cannot be truly healthy without good oral health. The Division of Tobacco Prevention and Control is currently recruiting for a program administrator to coordinate youth prevention programs with regional contractors.

Bureau of Epidemiology -- Ronald Tringali, PhD, RN

The Bureau of Family Health's designated Epidemiologist is Ronald Tringali, PhD, RN. Prior to serving in this position, Dr. Tringali served as Section Chief for the Health Assessment Section of the Division of Environmental Epidemiology and as Epidemiologist for the statewide Breast and Cervical Cancer Program. Dr. Tringali was also the Research Clinical Nurse Specialist for the Center for Nursing Research at the Penn State Milton S. Hershey medical Center. Dr. Tringali has held an adjunct appointment in the School of Nursing at the University of Pittsburgh.

Chief Counsel's Office -- Rachel Hammond, Esq.
The Bureau of Family Health's designated Attorney is Rachel Hammond. She attended the Pennsylvania State University and the Dickinson School of Law. Ms. Hammond provides legal counsel to the Bureau of Family Health programs (except WIC operations).

Bureau of Community Health Systems
The Division of School Health in the Bureau of Community Health Systems monitors and evaluates school entities' (500 school districts, 125+ charter schools, 10 comprehensive vo-tech schools, and 29 intermediate units) compliance with State laws, regulations, and policies; provides consultation and technical assistance to schools to support and improve health programs and services; develops policy, procedures, guidelines and adopts records and report forms to support and facilitate the efficient operation, administration and evaluation of the school health program; and fosters state and local cooperation and coordination of programs and services. These activities are facilitated through the efforts of two full-time State School Health Consultants who are funded by the Bureau of Family Health, led by the Division Chief.

E. State Agency Coordination

The Bureau of Family Health has significant collaborative relationships and coordinated efforts with other state agencies (described below), local health departments, the MCH Leadership Program at the University of Pittsburgh, other universities such as Drexel and University of Pennsylvania, and professional associations such as the PA- American Academy of Pediatrics, and the Pennsylvania Health and Hospital Association and family leadership and support programs such as the Parent Education and Advocacy Learning Center (PEAL Center).

Coordination with Multi-State Agencies

Through the Memorandum of Understanding for a Shared Agenda for Youth and Young Adults with Disabilities, members of the Pennsylvania Transition State Leadership Team (the Departments of Health, Labor and Industry, Public Welfare and Education), work together in supporting youth/young adults with disabilities transitioning into adult life. These four agencies, along with families, youth/young adults with special health care needs, and community partners address issues of youth as they transition out of secondary education. The group's work focuses on sharing data, building cost effective and natural support systems for youth, supporting statewide and comprehensive systems change, educating families and youth about transition, identifying gaps and opportunities in services and supports from across systems perspective. Two major accomplishments of the group are the annual statewide Transition Conference with scholarships for families and youth/young adults, and the distribution of the Secondary Transition Packet to all 14 year old youth/young adults in Pennsylvania's schools. The collecting of data ensures that quality services are delivered. By sharing data between agencies we can effectively improve the quality of services available to families of children with special health care needs without costly duplication.

Pennsylvania's Health and Human Services Call Center (HHSCC) is the result of a collaborative effort with Departments of Aging, Public Welfare and the Insurance Department. Through this partnership, each agency financially supports their respective helplines, but collaboratively works to support the Call Center as a "one call" source of information for Pennsylvania citizens. An individual, for instance, can be provided with information about breastfeeding for their infant, lead poisoning prevention for their preschooler, medical insurance during an economic downturn, learn

about recreational opportunities for a child with special health care needs and find services for their aging mother through a single call. Agency line managers meet on a monthly basis with HHSCC staff to discuss operational needs, issues of mutual benefit for callers, and expansion of the Call Center. Outreach activities are shared by agency representatives and HHSCC staff. Informational materials from various helplines are provided to outreach participants for distribution to the public. This collaborative effort has strengthened the work of the agencies through networking opportunities that continue to create more responsive systems for all citizens.

Senate Bill 246, Pennsylvania's Clean Indoor Air Act (CIAA), passed on June 10, 2008 and became effective on September 11, 2008. This legislation named the Department of Health (DOH) the lead agency for implementation of the CIAA. Eliminating exposure to secondhand smoke (SHS) and promoting cessation are two evidence-based strategies cited by the U.S. Centers for Disease Control and Prevention (CDC) that can contribute to a reduction in disease, disability and death related to tobacco use and SHS exposure. Many reports and studies consistently document reductions in tobacco use following the implementation of smoke-free laws and policies.

The DOH partners with the following agencies to coordinate implementation and enforcement of the CIAA and to create an efficient application and reporting process for DOH to review exception requests for drinking establishments, cigar bars and tobacco shops:

- Department of Aging
- Department of Agriculture
- Department of General Services
- Department of Public Welfare
- Department of Revenue
- Office of Administration, Bureau of Labor Relations
- Office of General Counsel
- Pennsylvania Gaming Control Board
- Pennsylvania State Police
- Pennsylvania Liquor Control Board
- Bureau of Liquor Code Enforcement

The DOH eight regional Primary Contractors are responsible for providing tobacco use prevention and cessation services throughout the Commonwealth, including services relating to the implementation of the CIAA. All Primary Contractors have received training in the implementation of the CIAA and in the provision of technical assistance to affected establishments, and are assisting the DOH in the verification of exception requests.

The Departments of Health and Public Welfare contract with four regional Family Health Councils to support family planning services at approximately 246 local clinics throughout Pennsylvania. Utilizing funding from four different sources, these State agencies pay for services through one integrated reimbursement system utilizing a common fee schedule. Funding sources include the Department of Health's Title V funding for teens 17 years of age and under, the Department of Public Welfare's Title XIX and Title XX funding, and State funding for breast cancer screening and women's medical services. The United States Department of Health and Human Services Title X funding is provided directly to the Councils.

Bureau of Family Health staff, along with staff from the Department of Public Welfare's Office of Medical Assistance Programs and the Insurance Department's Children's Health Insurance Program (CHIP), participate in bi-monthly Reaching Out Partnership meetings to identify and coordinate common interests relating to services for individuals receiving Title V, Title XIX, and Title XXI services. This interagency work group coordinates activities to achieve shared outcomes for these populations. These activities include refining the definition and eligibility criteria of populations served, sharing data, linking provided services, and sharing of respective agency needs assessment and satisfaction survey data. This partnership has expanded beyond the three original Agencies to include all partner Agencies under the Health and Human Services Call Center.

The Interagency Committee to Coordinate Services Provided to Individuals with Disabilities, The IDEA Memorandum of Understanding, was established by the Governor's Executive Order in 1998. This MOU is the underpinning of a collaborative work effort among the Departments of Labor and Industry Office of Vocational Rehabilitation, Public Welfare, Education, and Health to improve coordination of service. The PA Community on Transition, State Leadership Team carries out the intent of the MOU and works together in supporting the post-school outcomes for youth and young adults with disabilities transitioning into adult life. The mission of the Leadership Team is to build and support sustainable community partnerships that create opportunities for youth and young adults with disabilities to transition smoothly from secondary education to the post-secondary outcomes of competitive employment.

Coordination with the Department of Public Welfare

The Bureau of Family Health works in partnership with the Department of Public Welfare (DPW) in a statewide effort aimed at encouraging pregnant women and new moms to sign up for text4baby. Text4baby, an innovative educational program of the National Healthy Mothers, Healthy Babies Coalition, is a free mobile text messaging service that provides pregnant women and new moms with health information to help them care for and give their babies the best possible start in life. Women who sign up for the service receive three text messages each week. The messages are timed to their due date or the baby's date of birth and focus on a variety of topics critical to maternal and child health: prenatal care, emotional well being, labor and delivery, smoking cessation, breastfeeding, mental health, immunizations and safe sleep. The messages continue through the baby's first birthday.

The Lead Poisoning Data Match project is a collaboration between the Division of Child and Adult Health Services (DCAHS) and DPW's Office of Medical Assistance Programs. The goal is to exchange information between agencies to identify children receiving Medical Assistance (MA) who have been tested for lead. The project operates per a Letter of Agreement signed by both Departments on July 24, 2009, paving the way for the transfer of data files on a quarterly basis. In addition to helping identify MA children tested for lead, the datasets and output files received from DPW are also used to update the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) with the MA Identification Numbers of children who have received lead tests. This creates a more accurate set of data regarding lead testing for MA children.

Another lead poisoning prevention collaboration between DCAHS and DPW is the dissemination of information DPW's Managed Care Hotline contractor. DOH Lead Section regularly meet with the DPW contractors and staff to present information about the operation of the Lead Poisoning Prevention and Control Program, explain what the program does, answer questions, and offer resources for further information. This collaboration ensures that the Case Management Guidelines are available to the managed care plans and supports use of, and adherence to, the Guidelines.

In 2009, staff from the DCAHS met with key staff from DPW's Office of Children, Youth and Families (OCYF) and with staff from the local Children and Youth offices in Philadelphia and Erie to develop a strategic plan to implement the Healthy Homes Foster Care project (funded by HUD). Grant objectives and the parameters of the proposed grant agreements with the cities of Philadelphia and Erie were agreed upon and an action plan was developed. The OCYF representatives agreed to support the Healthy Homes project. This plan resulted in the DCAHS receiving American Recovery and Reinvestment Act (ARR) funding to support this collaborative project. The OCYF offices provide ongoing referrals to the cities' Healthy Homes offices.

The Division of Community Systems Development and Outreach (CSDO) staff supported by the US Environmental Protection Agency (EPA) (State Lead Program) has a contractual relationship with the Lead Abatement Training Center in Danville, PA where Lead Contractor training services are provided. Through a Memorandum of Understanding, the DPW provides physical plant

oversight; the Department of Labor and Industry provides accreditation for trainers and certification for individuals successfully completing training. The State Lead Program provides outreach opportunities in collaboration with the Health and Human Services Call Center for all programs within the CSDO, as well as the Lead Poisoning Prevention and Control Section located within the DCAHS. All print material disseminated through the Lead information Line is provided by the EPA State Lead Program.

The DCAHS and DPW contract with the four Family Health Councils to support family planning services at approximately 250 local clinics throughout Pennsylvania. Utilizing funding from different sources, services are reimbursed using a common fee schedule. Funding sources include: Title V (for teens 17 and under), Title XIX, and Title XX, and state funding for breast cancer screening and women's medical services. The United States Department of Health and Human Services Title X funding is provided directly to the four Family Health Councils.

The Division of WIC collaborates with the Department of Public Welfare (DPW) to help ensure the eligibility of WIC applicants. Federal WIC regulations require that individuals meeting other WIC eligibility criteria be considered income eligible if they are currently receiving Medical Assistance (MA), SNAP (formerly Food Stamps), and/or Cash Assistance (TANF). In order to ease the burden of proof on WIC applicants and ensure more accurate and up to date data, the Division of WIC has collaborated with the Pennsylvania Department of Public Welfare to link into their Client Information System (CIS). The Division of WIC worked closely with DPW staff to ensure there were adequate security measures in place to insure the confidentiality of data and the integrity of DPW's CIS system. Procedures were put in place to insure access to CIS only by authorized WIC users and then only with secure password protection. This access to DPW data speeds the WIC certification process and provides up to date accurate information so there is less chance of inappropriate WIC certifications.

The Bureau of Family Health routinely partners with DPW related to its administration of several programs utilized by MCH populations. Programs include state Medicaid (Medical Assistance), Early and Periodic Screening, Diagnosis and Treatment Program(EPSDT), mental health and substance abuse services (in conjunction with the Department of Health's Bureau of Drug and Alcohol Programs), developmental disability and early intervention, child welfare services including abuse, neglect, foster care and permanent placement, Temporary Assistance to Needy Families, and energy assistance services.

Coordination with the Department of Education

The BrainSTEPS program represents a unique opportunity for the Division of Child and Adult Health Services (DCAHS) to partner with the Pennsylvania Department of Education (PDE) on an issue of importance across Departments. The partnership with PDE facilitated critical access to school districts across the Commonwealth. Additionally, through this partnership, PDE supported the development and implementation of an on-line database utilized for BrainSTEPS reporting. In September 2007, the DCAHS, through a partnership with the Brain Injury Association of Pennsylvania implemented a Child and Adolescent Brain Injury School Re-Entry program entitled BrainSTEPS (Strategies, Teaching Educators, Parents and Students). The goal of the BrainSTEPS program is to facilitate the transition of children and adolescents back into the educational system following a brain injury. Through this program, a link is established between the trauma centers/rehabilitation hospitals and the special education team within the school. Teams are established who are available to families and schools throughout the Commonwealth. BrainSTEPS teams assist local school staff in developing educational programs, academic interventions, strategy implementation and monitoring of students who have sustained a brain injury.

The DCAHS collaborates with the Department of Education on several initiatives related to teen pregnancy prevention and preconception health. The DCAHS has coordinated efforts with the Department of Education on grant applications that will bring approximately $2.2 million dollars of

federal funding per year for five years into Pennsylvania. This money will be used in a statewide initiative to implement a comprehensive, evidence based teen pregnancy curriculum in ten large school districts throughout the Commonwealth. Additionally, the DCAHS and the Department of Education have collaborated to promote preconception health strategies for adolescents in a Preconception Health for Adolescents Action Learning Collaborative sponsored by the Association of Maternal and Child Health Programs (AMCPH). The goal of this initiative is to increase parent, educator, and primary care giver's awareness about the stages of adolescent development and have the associated communication skills to discuss these issues with adolescents.

Coordination with Department of Agriculture

The Division of WIC (WIC) is also venturing into a new collaboration with the Pennsylvania Department of Agriculture for the pilot of a program that would allow the use of WIC Cash Value Vouchers (CVV's) at Department of Agriculture authorized Farmer's Markets. WIC has collaborated with Agriculture for many years in the distribution of WIC Farmer's Market Coupons each summer, but the introduction of WIC CVV's, which are check like drafts that allow the purchase of a fixed amount of fruits and vegetables each month, allow a new opportunity to partner with the Department of Agriculture and the Farmer's Market Nutrition Program (FMNP). The summer of 2010 WIC is piloting the use of WIC CVV's in Adams and Franklin Counties. It is hoped this pilot will increase the use of both WIC CVV's and FMNP coupons and will provide an increased business opportunity for the farmers and farmers markets in this area of the state. This pilot will be evaluated after the conclusion of the Farmer's Market season and a determination will be made as to whether or not the pilot will be rolled out statewide in 2011.

Coordination with the Department of Aging

The Division of Newborn Screening and Genetics (Division) has a Memorandum of Understanding (MOU) with the Department of Aging (PDA) that allows the Division to take advantage of PDA's Pharmaceutical Assistance Contracts for the Elderly (PACE). The PACE Program is a large pharmaceutical assistance program for low-income Pennsylvania residents over age 55. The MOU allows the Division to expand the number of accessible pharmacies and consolidate pharmaceutical claims processing through a single administrative agency. The PACE Program administers cardholder application, enrollment processing, and pharmaceutical claims processing that includes prescription and non-prescription drugs, medical supplies, nutritional supplements, incontinent supplies, durable medical equipment and metabolic formula for the Division's Children with Special Health Care Needs programs including Spina Bifida, Cystic Fibrosis, and Metabolic Conditions. The PACE contractor provides professional and technical support to the Division regarding pharmaceutical services, including medical exceptions, formulary review, reports and assessment of drug utilization surveillance review, prospective drug utilization, drug product research, and written reports regarding relevance to end stage renal disease. In addition, PDA provides informal adjudication for any disputes arising from a pharmacy provider or cardholder enrollment, re-enrollment and eligibility, including denial of payment for claims submitted by providers and cardholder benefit cancellation, based on the requirement and appeal rights established by the Department of Health.

Other Agency Coordinated Efforts

The Bureau works collaboratively with a number of community based organizations that are focused on parent education and leadership. Through the State Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs, the PEAL (Parent Education, Advocacy and Leadership) Center provides parent leadership training to assist families in finding their voices and integrating them into the established Parent Youth Professional Forums. Additionally, PEAL has provided educational sessions on Medicaid 101 across the state to assist DOH in addressing the ongoing need for resources and information expressed by the parents and families. Other large parent organizations including Parent to

Parent and the Parent Education Network (PEN) also belong to the regional forums and assist in addressing parent needs. Parents of CYSHCN in the military are reached through networking with Military One Source and providing information and resources to them.

F. Health Systems Capacity Indicators

Introduction

The following indicators document the maternal and child health system capacity in the Commonwealth.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	43.4	47.1	45.3	41.8	
Numerator	3170	3442	3322	3082	
Denominator	731167	731116	732956	737202	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009

Data not available. Usually these data are available 11 to 12 months from the close of the calendar year.

Notes - 2008

ICD-9CM Codes for primary diagnosis.
Numerator source: PA Health Care Cost Containment Council
Denominator source: PA State Data Center

Notes - 2007

ICD-9CM Codes for primary diagnosis.
Numerator source: PA Health Care Cost Containment Council
Denominator source: PA State Data Center

Narrative:

From 2005 through 2008, the hospitalization rate for asthma for children aged 0-4 has fluctuated from a high of 47.1 admissions per 10,000 in 2006 to a low of 41.8 admissions per 10,000 in 2008. This represents an 11% decrease in the rate of hospitalizations related to asthma from 2006 to 2008. This decrease could be due, in part, to better outpatient management of asthma, resulting in lower hospital admission rates.

The Pennsylvania Department of Health (DOH) and Department of Public Welfare (DPW) will work collaboratively to develop and implement an in-home asthma education program. The purpose of the program is to provide in-home assessment, education and referral services for asthma patients. Medicaid recipients (ages 0-64 years) with a primary diagnosis of asthma who meet the Health Effectiveness Data and Information Set (HEDIS) criteria for poorly controlled asthma are eligible to participate. It has been reported that asthma programs with close ties to the community, with robust interactions with other agencies, and with an intensive home trigger

control component were most successful in reducing asthma hospitalizations.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.7	75.4	80.0	80.0	81.7
Numerator	56096	56739	59604	59604	62154
Denominator	68651	75220	74502	74502	76063
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator data is from the CMS416 Report for the service date period 10/01/08 - 9/30/09. The denominator is the number of Medicaid enrollees who are less than one year old as of 09/30/09. Source: PA Department of Public Welfare.

Notes - 2008
Numerator data is from the CMS416 Report for the service date period 10/01/07 – 09/30/08. The denominator is the number of Medicaid enrollees who are less than one year old as of 09/30/08. Source: PA Department of Public Welfare

Notes - 2007
Numerator data is from the CMS416 Report for the service date period 10/01/07 – 09/30/08. The denominator is the number of Medicaid enrollees who are less than one year old as of 09/30/08. Source: PA Department of Public Welfare

Narrative:
The percent of Medicaid enrollees whose age is less than one year receiving at least one initial or periodic screening has remained fairly consistent form 2005 to 2009 with a low of 75.4 in 2006 and a high of 81.7 in both 2005 and 2009.

On September 1, 2008 the Department of Public Welfare (DPW) updated the EPSDT Periodicity Schedule based on the recommendations of the American Academy of Pediatrics, the American Dental Association and the American Academy of Pediatric Dentistry.

DPW increased the reimbursements to encourage providers to perform complete EPSDT screens and to support the time it takes to perform a screen. Other updates included: (1) Adding newborn and hemoglobinopathy screenings as a required component for newborn screenings. (2) Adding additional periodic screens at 30 months, 7 years and 9 years of age (3) Adding developmental surveillance as a required component of all periodic screens newborn through 20 years of age except where structured developmental screenings are required (4) Adding structured screens for Autism Spectrum Disorders at 18 and 24 months of age (5) Adding referral to a dental home.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	53.0	62.8	66.5	75.2	80.4
Numerator	683	787	968	1359	1402
Denominator	1289	1253	1455	1807	1743
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are provided by CHIP contractors using HEDIS-like parameters and reported for federal fiscal year 10/01/09 to 09/30/09.
Source: PA Department of Insurance.

Notes - 2008
Data are provided by CHIP contractors using HEDIS-like parameters and reported for federal fiscal year 10/01/07 to 09/30/08.
Source: PA Department of Insurance

Notes - 2007
Numerator and denominator were provided by CHIP contractors using HEDIS-like parameters and reported for federal fiscal year 10/01/06 to 09/30/07.
Source: PA Department of Insurance

Narrative:
The percentage of CHIP enrollees less than one receiving at least one periodic screening has steadily increased from 2005 (53.0%) to 2009 (80.4%). This represents an increase of 52% from 2005 to 2009. While the Department of Insurance has not fully studied the reasons for the increases, a logical assumption is that advertising within the past few years has been more focused on wellness and preventative care. Prior to that time, most media was geared towards getting kids enrolled. In addition, the number of kids enrolled in CHIP has grown significantly, therefore, it is logical to assume that the number receiving a periodic screen would also increase.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	66.6	66.0	65.6	66.4	
Numerator	75623	75410	75142	78938	
Denominator	113626	114297	114467	118960	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Calculated with missing data (adequacy measure could not be computed) removed from denominator.
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Calculated with missing data (adequacy measure could not be computed) removed from denominator.
2004 data have been revised as of April 26, 2007.
Source: PA Department of Health, Bureau of Health Statistics and Research

Narrative:
The percent of women (15 through 44) with a live birth and whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index has remained steady over the past four years. Slight decreases occurred from 2005 (66.6%) to 2006 (66.0%) and again in 2007 (65.6%), with a slight increase in 2008 to 66.4%. Some of the risk factors for lack of prenatal care include giving birth before age 20, lack of a high school education, low income, and lack of proper health insurance. Programs that target individuals with these risk factors continue to need to be initiated in order to increase the number of women in both groups who seek prenatal care in their first trimester.

The Department continues to strive to remove barriers and enhance access to prenatal care, recognizing that early entry into prenatal care is one of the key components in the battle against infant mortality. The majority of the ten county/municipal health departments offer prenatal home visiting programs in an effort to reach at-risk or traditionally underserved mothers and families.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	92.0	88.9	74.9	74.9	75.7
Numerator	874776	882745	833162	833162	888994
Denominator	950670	993176	1112818	1112818	1174081
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator is based on claims having a date of service during the period 10/01/08 to 09/30/09, regardless of the claim adjudication date or payment date. Numerator is the number of children

age 0 to 20 who received a service approved by MA either through the Fee-for-Service or Managed Care Delivery System. DPW cannot provide a number for children potentially eligible for MA who did not apply. The denominator is the number of children who have been determined to be eligible for MA who are age 0 to 20 during the reporting period.
Source: PA Department of Public Welfare.

Notes - 2008
Numerator is based on claims having a date of service during the period 10/01/07 to 09/30/08, regardless of the claim adjudication date or payment date. Numerator is the number of children age 0 to 20 who received a service approved by MA either through the Fee-for-Service or Managed Care Delivery System. DPW cannot provide a number for children potentially eligible for MA who did not apply. The denominator is the number of children who have been determined to be eligible for MA who are age 0 to 20 during the reporting period.

Source: PA Department of Public Welfare

Notes - 2007
Numerator is based on claims having a date of service during the period 10/01/07 to 09/30/08, regardless of the claim adjudication date or payment date. Numerator is the number of children age 0 to 20 who received a service approved by MA either through the Fee-for-Service or Managed Care Delivery System. DPW cannot provide a number for children potentially eligible for MA who did not apply. The denominator is the number of children who have been determined to be eligible for MA who are age 0 to 20 during the reporting period.

Source: PA Department of Public Welfare

Narrative:
In 2005 the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program was 92.0%. By 2007, the percentage dropped to 74.9% and remained at that for 2008. However, in 2009 the percentage slightly increased to 75.7. This represents a decline of 17.7% since 2005.

The Commonwealth has made a strong commitment to reducing the number of uninsured children in Pennsylvania and ensuring access to healthcare services. Activities have included: Pennsylvania Act 136 of 2006 "Cover All Kids" expanded the income eligibility rules for the Children's Health Insurance Program (CHIP). Act 136 also allows the collection of co-pays for income levels greater than 200% of the Federal Poverty Limit. "Cover All Kids," expands CHIP to all children and families with incomes over 300% of the federal poverty level. The Act potentially assists children with special health care needs that are ineligible for Medicaid.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	38.6	38.3	41.4	40.3	48.3
Numerator	76564	79334	86749	85267	105835
Denominator	198133	206929	209765	211661	219317
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are from the CMS416 Report for the service date period 10/01/2008-09/30/2009.
Source: PA Depatment of Public Welfare

Notes - 2008
Data are from the CMS416 Report for the service date period 10/01/2007 – 09/30/2008. Note - the numerator data was updated after CMS416 Report was released.
Source: PA Department of Public Welfare

Notes - 2007
HSCI #07B: Data is provided to the Title V program by PA Department of Public Welfare, from their CMS416 Report for the service date period 10/01/2005 – 09/30/2006.

Narrative:
The percent of EPSDT eligible children aged 6 through 9 receiving a dental service rose during the 2005 to 2009 period from 38.6% to 48.3%, respectively. This represents a 25.1% rise in eligible children receiving dental services.

The Department of Public Welfare continues to focus on dental care and making sure each child is referred to a dental home.

In the Access Plus program Pay for Performance Program for Dental providers was started on July 1, 2008. Dental providers are reimbursed if the meet performance measures in each of the four metrics. Dental care for children under 21 years of age is one of the metrics.

Under this metric the performance areas include:
1. Completing a first dental care visit with an Access Plus patient that includes a comprehensive oral evaluation, prophylaxis and fluoride treatment for patients = 16 years of age.
2. Completing a periodic dental care visit with an Access Plus patient = 21 years of age that includes a comprehensive oral evaluation, prophylaxis and fluoride treatment for patients = 17 years of age.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.1	0.0	0.0	
Numerator	9	58	7	18	
Denominator	57809	56556	54477	56237	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available.

Notes - 2008
Since State SSI beneficiaries are eligible for Medical Assistance, the percent of beneficiaries receiving benefits from the State's CSHCN program is expected to be very low relative to the number of SSI beneficiaries in the State. The majority of identified SSI beneficiaries from the State's CSHCN program were children receiving comprehensive specialty care by multi-disciplinary teams.

Numerator is State Fiscal year data from CORE (SFY 08-09).
Denominator is number of children receiving SSI payments in PA as of December 2008, the Social Security Administration's December 2008 report at http://www.hrtw.org/youth/data.html#ssi08

Notes - 2007
Since State SSI beneficiaries are eligible for Medical Assistance, the percent of beneficiaries receiving benefits from the State's CSHCN program is expected to be very low relative to the number of SSI beneficiaries in the State. The majority of identified SSI beneficiaries from the State's CSHCN program were children receiving comprehensive specialty care by multi-disciplinary teams.

Numerator is State Fiscal year data from CORE (SFY 07-08).
Denominator is number of children receiving SSI payments in PA as of December 2007, the Social Security Administration's December 2007 report.

Narrative:
Due to small numbers trending is not possible for this Indicator. The Bureau funds services for individuals with complex medical conditions such as Hemophilia, Spina Bifida, Cooley's Anemia, Cystic Fibrosis, Child Rehabilitation, and Sickle Cell Disease through the Bureau's Comprehensive Specialty Care and Sickle Cell Disease Programs. Funding helps support Multidisciplinary Team Clinics at university-based medical centers. The one-stop multidisciplinary team clinic visits afford patients a full gamut of necessary services to manage their complex medical condition. As the name "multidisciplinary" implies, the clinics support a broad array of service providers who collaborate to provide comprehensive care and coordinate care to a greater extent than typical insurance reimbursements would allow. In addition, they provide professional expertise and outreach to community-based provider networks, family members and school staff to help them manage and coordinate care for these complex medical conditions. Services include specialized physician and surgical care, nutrition, case management, social work services including psychosocial support and links to community resources, laboratory, radiology, pharmacology, speech therapy, physical therapy, occupational therapy, orthotic care, dental care and health education.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	10.4	7.1	8.3

Narrative:
The data source for this indicator is the payment source noted on the birth certificate. In 2008, 10.4% of all Medicaid births were low birth weight (LBW) compared to 7.1% of Non-Medicaid births. This represents a slight decrease from 2007, 10.6% of all Medicaid births being low birth weight and 7.2% of all Non-Medicaid births being low birth weight. In 2006 10.8% of all PA Medicaid births were low birth weight compared to 7.3% of Non-Medicaid births. These statistics show that Medicaid recipients are still at higher risk for delivering low birth weight infants than non-Medicaid recipients. This suggests that more targeted intervention programs should be offered to pregnant mothers who are receiving Medicaid to decrease this disparity.

The percentage of LBW babies born in Pennsylvania has remained fairly constant over the last three years as has the disparity in LBW between Medicaid and non-Medicaid births. Additionally, Pennsylvania's LBW percentage is relatively consistent with the national LBW percentage. Like many other states, Pennsylvania continues to see great disparity in the percentage of LBW babies born to black women versus white women (13.5% versus 7.1% respectively). In an effort to increase awareness about the importance of prenatal care, the Bureau has begun to explore non-traditional mechanisms to educate the public. To this end, the Bureau has initiated a relationship with the faith-based community in Philadelphia to provide education and awareness about the importance of prenatal care.

In July of 2009 the Enhanced Primary Care Case Management delivery system for Pennsylvania Medicaid implemented a pay for performance program targeting dentists who provide dental care to pregnant women in an effort to reduce the incidence of pre-term labor and possibly LBW babies.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	other	0	0	7.3

Notes - 2011
Infant deaths per 1,000 live births: The Title V program does not have the capability to break the data into Medicaid and non-Medicaid for this section.

Narrative:
The Title V program does not have the capability to break the Infant deaths per 1,000 live births data into Medicaid, non-Medicaid, and all populations in the State. However, the overall infant death rate dropped slightly from 2007 to 2008, 7.5 and 7.3, respectively. Risk factors for infant deaths include: congenital defects, preterm birth, maternal complications, low birth weight, and SIDS.

The Bureau continues to be concerned about the overall infant mortality rate and more specifically about the disparity in infant mortality rates among certain racial and ethnic minorities.

The Bureau has recently identified infant mortality as a priority area for Title V. To that end, the Bureau has identified areas of the Commonwealth where the infant mortality rate is particularly dire and has been developing creative strategies and interventions aimed at addressing this issue. Specific interventions include home visiting programs, prenatal care for uninsurable women, faith based initiatives, community round table discussions, and community intervention grants.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	69.4	84.3	79.4

Narrative:
In 2008, 69.4% of Medicaid covered pregnant women giving birth received prenatal care in their first trimester compared to 84.3% of Non-Medicaid covered women, remaining consistent with 2007 data (69.9% - Medicaid: 84.4% - Non-Medicaid). The data source for this indicator is the payment source noted on the birth certificate. In 2006, 70.1% of Medicaid covered pregnant women giving birth received prenatal care in their first trimester compared to 84.7% of Non-Medicaid covered women. Some of the risk factors for lack of prenatal care include giving birth before age 20, lack of a high school education, low income, and lack of proper health insurance. Programs that target individuals with these risk factors continue to need to be initiated in order to increase the number of women in both groups who seek prenatal care in their first trimester.

Recognizing the importance of early entry into prenatal care, the Bureau prenatal programs strive for initiation of prenatal care in the first trimester. Additionally, the Department now has the benefit of a partial year dataset from the Pregnancy Risk Assessment Monitoring System (PRAMS). The Bureau can now begin analyzing PRAMS variables including initiation of prenatal care in order to implement specific evidence base programming.

Pennsylvania Medicaid makes every effort to ensure that pregnant women have access to provider for prenatal care as soon as the woman feels she may be pregnant. Efforts include outreach calls to all new members, or women who identify themselves as being pregnant to assist with scheduling prenatal care appointments, availability of nurse care managers specializing in maternity care and providing transportation to appointments as needed.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	63.4	68	66.4

Narrative:
In 2008, the percent of Medicaid covered pregnant women giving birth who received adequate prenatal care was 63.4% versus 68.0% of Non-Medicaid covered pregnant women giving birth. These figures have remained consistent with the 2007 figures (63.4% -- Medicaid: 67.1% -- Non-Medicaid). The data source for this indicator is the payment source noted on the birth certificate. Even though Medicaid covered women have a lower rate of adequate prenatal care; there is still a large number of Non-Medicaid covered women who are not receiving adequate prenatal care. Some of the risk factors for lack of prenatal care include giving birth before age 20, lack of a high school education, low income, and lack of proper health insurance. Programs that target individuals with these risk factors continue to need to be initiated in order to increase the number of women in both groups who seek prenatal care in their first trimester.

The Bureau continues to strive to remove barriers and enhance access to prenatal care, recognizing that early entry into prenatal care is one of the key components in the battle against infant mortality. The majority of the ten county/municipal health departments offer prenatal home visiting programs in an effort to reach at-risk or traditionally underserved mothers and families.

Pennsylvania Medicaid has in place a "pay for performance" program for both its Managed Care and Enhanced Primary Care Case Management delivery systems which provides the vendors with rewards for women who have received adequate prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Notes - 2011
The percent of poverty level for eligibility in PA's Free CHIP program for infants under 1 is 185%-200% of the Federal Poverty Level (FPL).

Narrative:
The Medicaid income limits used to determine eligibility for pregnant women and infants up to age one is 185% Federal Poverty Income Guidelines (FPIG). On November 2, 2006, Governor

Rendell signed into law Act 136 of 2006, making Cover All Kids a reality by expanding the income eligibility rules for the Children's Health Insurance Program (CHIP) and allowing the State to collect a monthly premium as permitted by the Federal Government. The CHIP expands medical coverage for families with an income over 300% of the federal poverty level. The "Cover All Kids" initiative could potentially provide medical insurance for families with children with special health care needs that are ineligible for the Medicaid Program. The initiative enables qualified families to purchase coverage at the Commonwealth's rate of $150.00 a month per child, potentially assisting children with special health care needs that are ineligible for Medicaid. To receive CHIP coverage for free, children must be in households with incomes no greater than 200% of poverty. Children in households with incomes between 200% and 300% of poverty can receive coverage by paying a low monthly premium that is adjusted according to income. Children in households with incomes above 300% of poverty may purchase coverage at the full state-negotiated rate. A current policy dictates that children eligible for Medical Assistance cannot be also enrolled in CHIP.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 200 200

Notes - 2011
The percent of poverty level for eligibility in PA's Free CHIP program for children 1-5 is 133% - 200% FPL.
The percent of poverty level for eligibility in PA's Free CHIP program for children 6-18 is 100% - 200% FPL.

Narrative:
The Medicaid income limits used to determine eligibility for age one to age six is 133% of Federal Poverty Income Guidelines.

Despite budgetary pressures, the income thresholds to qualify for CHIP have not changed since the expansion of the income guidelines in 2007. To qualify for CHIP, household income must be above the upper limit for Medicaid and not exceed the following guidelines for varying degrees of government subsidization:

Free CHIP (100% subsidy) = 200% of the federal poverty level
Low cost CHIP (75% subsidy) = 250% of the federal poverty level
Low cost CHIP (65% subsidy) = 275% of the federal poverty level
Low cost CHIP (60% subsidy) = 300% of the federal poverty level
Full cost CHIP (no subsidy) = incomes above 300% of the federal poverty level

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	

Notes - 2011
SCHIP coverage is non-applicable for pregnant women.

Narrative:
The Department of Public Welfare (DPW), Office of Medical Assistance Programs, recognizing the importance of seamless, consistent prenatal care is instituting the Pilot for Pregnant Women. Since 2004, under this pilot program, eligible women have begun Medicaid coverage as soon as they are determined to be pregnant and then rapidly transitioned into managed care. This pilot program combines flexible eligibility guidelines with a simplified application and eligibility determination process to enable eligible pregnant women to obtain comprehensive primary care during pregnancy and the postpartum period. This pilot program will prevent gaps in service for pregnant women and provide earlier enrollment in prenatal programs to ensure quality care for pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND	1	No

SURVEYS Hospital discharge survey for at least 90% of in-State discharges		
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The Bureau has been collecting Pregnancy Risk Assessment Monitoring System (PRAMS) surveys since September 2007. The first available PRAMS response dataset -- the 2007 partial year dataset -- became available for analysis last year within an on-line query system. In April 2009, the dataset was loaded in to the Centers for Disease Control and Prevention (CDC) PRAMS Online Data for Epidemiologic Research (PONDER) system. The 2008 PRAMS response dataset has only recently been weighted and made available to Pennsylvania; it has not yet been loaded in to PONDER. Using PONDER, two separate data briefs have been developed and disseminated. The first one, reflecting analysis on 2007 postpartum depression related response variables crossed with maternal demographics has been finalized. It was presented to PA's Maternal & Child Health nurse consultants during a presentation in January, 2010. And, it was subsequently presented in April to members of the Pennsylvania Perinatal Partnership. Additionally, both data briefs have been shared internally with program staff in an effort to disseminate PRAMS analysis, and inform and evaluate programs aimed at promoting positive maternal and infant health. Response datasets will continue to be analyzed, and data briefs will continue to be generated. Finalized reports and data briefs will be available on the PRAMS website. It is expected that this analysis will continue to serve to inform program policies, evaluate program outcomes, set priorities and, ultimately, positively impact maternal and infant health.

The Pennsylvania Child Death Review (CDR) Program uses child death data to drive programs. Information derived from local child death reviews is used to develop inter-disciplinary training, community-based prevention education, and data-driven recommendations for legislation and public policy. The data that is collected follows a national protocol which is part of the National CDR Resource database.

OZ eSP, has been selected as the web-based system application to integrate the Newborn Hearing Screening and Metabolic Newborn Screening files to provide more timely and accurate information regarding the total number of newborns receiving both newborn hearing and metabolic screening. The system is under development for programmatic elements related to the Metabolic screening program with an expected completion for Fall 2010. The system will allow for more complete data collection specific to the additional metabolic and genetic conditions for follow up as required by Act 36.

The Bureau established seven strategies associated to the State Systems Development Initiative HRSA grant award in 2006: link birth records to newborn screening files; match birth record to WIC files; improve newborn screening links; integrate PRAMS data into other DOH programs; explore DOH and MA file links; match NSFP files to death records; and match birth and death records to hospital discharges for birth defects surveillance.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2011

Narrative:
The Department of Health follows the recommendations of the Centers for Disease Control and Prevention (CDC) for comprehensive tobacco control programs, using a set of best practices with the four main goals, which include: Prevent the initiation of tobacco use among young people, Eliminate nonsmokers' exposure to secondhand smoke, Promote quitting among adults and young people, Identify and eliminate tobacco-related disparities.

One of the key components to these best practices is surveillance and evaluation, which gives policymakers and others responsible for fiscal oversight a way of monitoring outcomes. The Youth Tobacco Survey (YTS) is a tool developed by CDC to measure students' tobacco-related knowledge, behaviors, and attitudes.

The YTS has been conducted by the Pennsylvania Department of Health, Division of Tobacco Control and Prevention biannually since 2000; most recently during the fall and winter of the 2008/09 school year. The results of this survey are intended for use by tobacco control program staff, researchers, healthcare providers, local health departments, community partners and concerned private citizens.

• In 2008/09 school year, 26.2% of high school students (95% CI: 23.2-29.4%) smoked cigarettes, which is unchanged since 2006/07.
• In the 2008/09 school year, 4% of middle school students (95% CI= 3-6%) smoked cigarettes, which is unchanged since 2006/07.
• Eighteen percent of high school students (CI=16-21%) in the school year 2008/09 smoked cigarettes, which is the same as the 2006/07 rate of 18% (CI=15-20%).
• There were no significant differences in the rates of smoking between males and females in either high school or middle school.
• Among middle school students, three percent (CI=2-5%) and among high school students, nine percent (CI=7-11 percent), had used smokeless tobacco in the past 30 days.

The DTPC utilizes a regionalized approach for the delivery of comprehensive, integrated, and community-based tobacco prevention and cessation programs and initiatives. Regional primary contractors provide these services in each of the Department's six Community Health Districts and in Allegheny and Philadelphia Counties.

Tobacco Free Allegheny (TFA) developed a toolkit entitled Pennsylvania's 100% Tobacco Free Schools Toolkit for Student Assistance Programs. The toolkit is designed to provide the most recent information about teens and tobacco, including evidence based prevention curricula; strategies to help teens quit tobacco and specific information tailored for parents, schools and teens. The comprehensive kit includes tools, templates and information on implementing effective policies to promote tobacco free schools. Designed for administrators, counselors, social workers, student assistance professionals (SAP) and educators, the toolkit is Pennsylvania-specific, and available in a convenient downloadable PDF format.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Bureau of Family Health, contracted with REDA International, Inc. in 2009-10 to conduct a five year statewide assessment of maternal, child and family health. This process is described earlier in this application. The purpose of this assessment of maternal, child and family health was to gather and present current information about the health and well being of the women, infants, children and children with special health care needs (CSHCN) residing in the Commonwealth. The assessment was conducted under the auspices of the Federal Title V Maternal and Child Health Program in accordance to the mandate to states to conduct an in depth maternal and child health needs and capacity assessment every five years.

The Bureau of Family Health assembled Title V stakeholders from across the state of Pennsylvania for the purpose of prioritizing Title V needs. The Bureau contracted with a nationally recognized expert, Andrew C. Rucks, Ph.D., University of Alabama-Birmingham, to facilitate the priority setting process using the Q-Sort technique. The purpose of the Q-Sort process is to identify priorities among competing needs. However, not all needs can be the "highest priority" for the state MCH program. The Q-Sort Technique is effective at getting information from people with different backgrounds.

A set of 50 "priority needs" was provided to the MCH stakeholders based upon the results of the Needs and Capacity Assessment. Each priority need was assigned a numeral as a label, with the labels having no relationship to priority order or value of the priority need. The set of 50 priority needs were converted to decks of 50, 3inch-by-5inch cards. Each card contained a label and its associated Priority Need Statement. Stakeholders were assembled in large room set-up in classroom style with tables. Each stakeholder was given one deck of cards and two Q-Sort Log Sheets . Dr. Rucks presented the group with: 1) an overview of the Q-Sort technique; 2) an overview of the strategy for arranging Priority Need Statements into priority sets; 3) specific instructions about placing the cards in descending order of priority and how to complete the Log Sheet; and 4) a presentation of the results of analyzing the data collected using the Log Sheets .

The assembled stakeholders applied the Q-Sort technique to assign each of the 50 Priority Need Statements to one of nine priority categories. Data generated by the stakeholders was analyzed using the traditional technique applied to Q-Sort data and enhanced analysis to offer additional information to the Title V decision makers. Consensus was reached by the stakeholders on the categorical assignment of 39 of the 50 Priority Need Statements.

Priorities were ranked according to the three populations to be served by Title V including: pregnant women and mothers, children, and children with special health care needs. An overarching priority of developing a comprehensive, cohesive statewide MCH policy is necessary to serve as a "catch-all" for priorities identified that cross multiple state agencies or funding sources and those which require attention at the Governor's level (these issues include: ensuring all Pennsylvanians have affordable health insurance, integrate behavioral and physical health care, improve access to oral health services, comprehensive programming to address obesity, expanding the number of providers who serve low income and uninsured individuals, expanding availability of dental care providers accepting Medicaid in underserved areas).

As a result of the Q-Sort technique and stakeholder consensus, the Bureau has selected the following 10 priorities (it should be noted some priorities were collapsed or combined where determined appropriate and feasible and any priority that is a state mandate (e.g. Newborn Screening) or Governor's Office initiative (e.g. Medical Home) was excluded from the list.

Items 1-3 are priorities related to Mothers and Infants. Item number 1 was the highest ranked (weighted) item in the Mothers and Infants category, followed by numbers 2 and 3 respectively. Items 4-7 are priorities related to Children and Adolescents. Within this cluster, item 4 was the

highest ranked (weighted) item in the Children and Adolescent category followed by numbers 5, 6 and 7 respectively. Items 8-10 are priorities related to Children with Special Health Care Needs (CSHCN). Within this cluster, item 8 was the most highly ranked (weighted) in the CSHCN category, followed by items 9 and 10, respectively.

1. Decrease barriers for prenatal care for at-risk/uninsured women through implementation of best practices
2. Reduce infant mortality rate for minorities
3. Increase behavioral health (mental health and substance abuse) screening, diagnosis and treatment for pregnant women and mothers (this includes post partum depression)
4. Decrease teen pregnancy through comprehensive sex education
5. Increase screening for mental health issues among infants, children and adolescents
6. Expand access to physical and behavioral health services for high risk youth such as LGBTQ, runaway/homeless
7. Expand injury prevention activities (including suicide prevention), for infants, children and adolescents
8. Increase awareness of and access to comprehensive information about services and programs for CSHCN
9. Improve the transition of children and youth with special health care needs (CYSHCN) from child to adult medical, educational and social services
10. Identify strategies for increasing respite care for caregivers

B. State Priorities

1. Decrease barriers for prenatal care for at-risk/uninsured women through implementation of best practices

Barriers to prenatal care, particularly for low income, at risk families are significant. The BFH will explore what best practice models could be introduced within the framework of existing programs. For example, Centering Pregnancy Initiatives have shown promise. The BFH will work with stakeholders to identify and address structural barriers such as wait times, inflexible scheduling and waiting room accommodations. Linguistic and cultural competency issues among providers are other key barriers that must be addressed. In one promising strategy, Medicaid has eliminated lag times associated with determining eligibility for pregnant women. Temporary outpatient prenatal services are provided to pregnant women determined to be presumptively eligible. The Medicaid program has increased fees for certain high risk pregnant women enrolled in Healthy Beginnings plus. Additionally, the Medicaid program has set aside dedicated funding to insure the availability of quality obstetrical and neonatal health care services for low income pregnant women.

2. Reduce infant mortality rate for minorities

The BFH will address the high infant mortality rate among blacks through a variety of initiatives that involve partnerships between federal, state, and local governments, hospitals, and academic institutions, faith based organizations, and the community. To the degree possible the BFH is interested in implementing the Life Course Model in its various grant agreements with provider agencies and local Title V agencies. Pennsylvania is in the preliminary stages of implementing a home visiting program in conjunction with the Federal Maternal, Infant and Early Childhood home visiting program.

In addition, the mission of the BFH Newborn Screening Program (NSP) is to eliminate or reduce the mortality, morbidity, and disabilities that result from the disorders included in the screening panel, and the rapid follow-up of all infants with an abnormal screening test result. The primary function of the NSP's follow-up component is to locate infants with screening results that are

screen positive and to facilitate the entry of these infants into the diagnostic and management components of the Newborn Screening and Follow-up Program in a timely fashion.

3. Increase behavioral health (mental health and substance abuse) screening, diagnosis and treatment for pregnant women and mothers (this includes post partum depression)

Depression in pregnant women and mothers poses serious risks to children in Pennsylvania each day, yet very often goes undetected and untreated. Depression in pregnant women and mothers poses serious risks to children in Pennsylvania each day, yet very often goes undetected and untreated.

According to Vericker, Macomber, and Golden, 11% of infants living in poverty have a mother suffering from severe depression, and compared with their peers with non-depressed mothers, infants living in poverty with severely depressed mother are more likely to have mothers who also struggle with domestic violence and substance abuse (Urban Institute. Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve. Brief 1, August 2010). Vericker et al., also point out that the majority of infants with severely depressed mothers (96%) live with someone who received benefits from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

Because WIC is a first intervention point to reach many low-income mothers, the BFH will offer behavioral health screening and referral for women at participating WIC clinics and/or their umbrella agencies through the use of MCH/SHCN Consultants or other state health staff. The BFH will research appropriate screening tools; the Institute for Health and Recovery's "5 P's" screening tool shows promise for utilization in WIC clinics with the target population.

Pennsylvania's County Municipal health departments have integrated screening for perinatal depression into their prenatal and postpartum home visiting programs. The Department of Public Welfare, recognizing the need to improve social-emotional outcomes for young children convened the Early Childhood mental Health Advisory Committee. In 2009, this Committee issued formal recommendations which include improving access to and coordination of services for young children and promoting competencies among professionals that serve children ages 0 to 5.

4. Decrease teen pregnancy through comprehensive sex education

Pennsylvania continues to work to decrease the teen pregnancy rate. The BFH has applied for the Tier One Teenage Pregnancy Prevention: Replication of Evidence-based Programs funding. If selected for funding, these funds would be used to implement the evidence-based program "Making Proud Choices" in schools, in the community through county/municipal health departments and a family health council. The BFH has also applied for the State Personal Responsibility and Education Program (PREP) funds. The PREP funds are formula grants to states. PREP funds will be used to implement an evidence-based program and to educate youth on adulthood preparation subjects in juvenile detention facilities, drug and alcohol treatment facilities, and mental health treatment facilities. The BFH has applied for the Title V State Abstinence Education Grant. The Abstinence Education funds will be used to implement an evidence-based abstinence program with the following population groups: black and/or Hispanic youth, youth in foster care, and youth with disabilities and/or other special health care needs. Finally, the BFH continues to fund the four family planning councils in the Commonwealth to provide reproductive health services to teens 17 years of age and younger. The Department of Education(PDE) and the Department of Public Welfare (DPW) have collaborated in a joint effort to assist expectant and parenting youth receiving TANF or SNAP through the Education Leading to Employment and Career Training (ELECT) Program. ELECT program services include support through education groups, individual meetings, and curriculum-driven courses. These programs also provide intensive case management, attendance monitoring, and secondary pregnancy prevention. In 2008-09 the ELECT program enrolled a diverse group of 5,291 secondary school students at-risk for academic failure because they are pregnant or parenting. In addition, the

Department of Education has applied for federal funds to support pregnant and parenting teens. If awarded the Department of Education will use these funds to provide services similar to the services provided in the ELECT program to teens who are not eligible for the ELECT program.

5. Increase screening for mental health issues among infants, children and adolescents

Poor circumstances, negative early experiences and lack of emotional support during normal growth and development can form the basis of the individual's human capital, which affects health throughout life. As cognitive, emotional and sensory development occur insecure or poor emotional attachment can lead to reduced readiness for school, low educational attainment and problem behavior in adolescents.

Because WIC is a first intervention point to reach many low-income infants and children, the BFH will offer mental health screening and referral at participating WIC clinics and/or their umbrella agencies through the use of MCH/SHCN Consultants or other state health staff. The BFH will research appropriate screening tools for infant and child mental health.

The Department of Public Welfare's Office of Mental Health and Substance Abuse Services was recently awarded a Garrett Lee Smith Grant. The Garrett Lee Smith Memorial Act provides funding for States, tribes and colleges/universities to develop and implement youth, adolescent and college-age early intervention and prevention strategies to reduce suicide.

6. Expand access to physical and behavioral health services for high risk youth such as LGBTQ, runaway/homeless

The health needs of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth are often not known by research and health authorities, and even when known, are often ignored and/or underfunded. Currently there are no known specific statewide programs that address the health issues faced by LGBTQ and/or runaway/homeless youth. The BFH will work with adolescent health, mental health, and drug and alcohol clinics to target LGBTQ youth. Few providers target LGBTQ youth with marketing and outreach. LGBTQ youth are likely to respond favorably to advertisements in local LGBTQ service directory and publications. In order to ensure that providers create a welcoming environment the BFH will provide cultural competency training to participating providers.

7. Expand injury prevention activities (including suicide prevention), for infants, children and adolescents

The Commonwealth currently engages in a number of activities aimed at expanding injury prevention for infants, children and adolescents. Notably, the Department of Health is responsible for administering the Commonwealth's Child Death Review (CDR) Program. The goal of CDR is to reduce the incidence of preventable child deaths through the multi-disciplinary reviews of child deaths and through the implementation of targeted prevention efforts aimed at Pennsylvania's most vulnerable populations. Additionally, the Department administers the Violence and Injury Prevention Program and oversees the Injury Community Planning Group (ICPG). The ICPG endeavors to develop a comprehensive and coordinated injury prevention effort.

Pennsylvania is also home to the Cribs for Kids safe sleep initiative. Cribs for Kids is a safe-sleep education program for low-income families aimed at reducing the risk of injury and death of infants due to unsafe sleep environments.

As part of the Federal Traumatic Brain Injury (TBI) grant, the Department of Health is the lead agency in a number of initiatives aimed at increasing awareness regarding brain injury. These activities consist of providing TBI education in child care facilities including revising the Safe Active Play self learning module to include information about TBI, partnering with the

Pennsylvania Chapter American Academy of Pediatrics to provide continuing medical education trainings to physicians, pediatric practices and family physicians and increasing TBI screening opportunities for victims of domestic violence and their children.

8. Increase awareness of and access to comprehensive information about services and programs for CSHCN

The Bureau of Family Health's Special Kids Network (SKN) helpline within the statewide Health and Human Services Call Center (HHSCC) is a free statewide resource for families with individuals who have special need and links callers to a broad range of services specifically CYSHCN. Through the Special Kids Network System of Care (SOC), the Bureau of Community Health Systems' Family Health Nursing Services Consultants (FHNSC) also link individuals to needed services, identify services in their communities, coordinate follow up referrals for services through the SKN Helpline, and convene Parent Youth Professional Forums statewide to provide input on programs and services as well as opportunities for family centered input on how to improve the systems and services for CYSHCN. The Pennsylvania Chapter of American Academy of Pediatrics (PA AAP) Medical Home program and the Pennsylvania Elks Home Service Program provide a roadmap to care through community based care coordination to families of CYSHCN. PA AAP's 43 Pennsylvania Medical Home Trainee Practices provide information to families about services as central caregivers for CYSHCN. Another source of positive impact on access to information for families of CYSHCN is the PA CARES Task Force. This task force is a diverse organization that locates and identifies services for military and veteran families who are geographically dispersed throughout Pennsylvania and experience limited access to comprehensive information about services and programs in their state and communities. The PA Developmental Disabilities Council and the Governor's Advisory Committee for People with Disabilities, both housed in the Department of Public Welfare (DPW), identify and fill gaps in services, and DPW also provides a forum for distributing information via the Disability Advocacy and Support Hub and Home and Community Based Services forums. Some of these programs (such as SOC) are young and activities should produce a noticeable increase in access to information; most are well-established and have the capacity to develop new initiatives to impact access to information.

9. Improve the transition of children and youth with special health care needs from child to adult medical, educational, and social services.

Pennsylvania is committed to the philosophy that children and youth with special health care needs are entitled to fully participate within their communities and their schools, and enjoy full adult lives. This year the Transition State Leadership Team (SLT), consisting of designees from the Departments of Health, Education, Public Welfare, Labor and Industry, has revised the Memorandum of Understand for a Shared Agenda for Youth and Young Adults with Disabilities. This renew efforts reflects our commitment to work together to support youth and young adults with disabilities to transition into adult life in the achievement of their desired post-school outcomes, with a focus healthy lifestyles, secondary education, training and lifelong learning, employment, and community participation. The Pennsylvania Community on Transition Conference has signified the importance of health for transitioning youth and young adults by adding a "health track" this year. Through collaboration with the Pennsylvania Chapter of the American Academy of Pediatrics (PA AAP) and the bureau, this "health track" yielded 18 health related sessions that were very informative and well received. Its success has lead to the inclusion of the track in next year's conference planning activities. Through the work of the State Implementation Grant for Integrated Community Systems for Children with Special Health Care Needs, a Transition Learning Collaborative has been initiated. This group involves 25 public and private professionals, youth and parents in four work groups on transition: Resource Identification, Integration of Disciplines, Medical Provider Issues and Youth Wellness/Self Advocacy. In addition, three medical practice sites (Pittsburgh, Allentown and Reading) are involved in transition pilot projects.

10. Identify strategies for increasing respite care for caregivers

Pennsylvania is one of the twelve new states that have been awarded the Lifespan Respite Grant through the US Administration on Aging. Through collaboration with the Pennsylvania Lifespan Respite Coalition, the Department of Public Welfare (DPW), the Department of Aging, Pennsylvania's network of Aging and Disability Resource Centers, and the Department of Health (Special Kids Network System of Care/Medical Home Program) the Commonwealth will enhance and expand opportunities for respite care across all ages including CYSHCN, and adults with disabilities and the elderly. Under this grant collaborating state agencies will work with existing local community and statewide resources to make it easier for families to access respite services. The Special Kids Network System of Care and the Lifespan Respite Coalition will update the Family Guide to Respite Care which identifies what respite care is and how to coordinate it and provides information on existing services, their eligibility requirements, and how services are provided. This effort will increase awareness and access to services as well as expand and strengthen respite care services to family caregivers of children or adults of all ages with special needs. Grantees will also strengthen statewide dissemination and coordination of respite care, improve access to respite programs, and enhance the quality of respite care services. The ultimate goal of these activities is the reduction of family caregiver strain.

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	212	197	200	211	289
Denominator	212	197	200	211	289
Data Source				See Field Level note	See Field Level Note
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Source: Division of Newborn Screening and Genetics

Notes - 2008

Source: Division of Newborn Screening and Genetics

Notes - 2007
Source: Division of Newborn Screening and Genetics

a. Last Year's Accomplishments
The NSFP has met the performance objective for this performance measure 100 percent for every year from 2003 to 2009.

Approximately 148,000 newborns were screened in 2009 with follow up provided for all abnormal results to include the coordination of obtaining filter papers for repeat testing and referrals to treatment centers for confirmatory testing and diagnosis. Expanded screening for the additional metabolic and genetic conditions required by Act 36 implementation started on July 1, 2009. In preparation for these additional requirements, the NSFP worked with its Technical Advisory Board to develop protocols to guide the follow up and referral process. A contract was initiated with OZ eSP, to provide an integrated state of the art newborn metabolic and hearing screening tracking, reporting and data management system for the additional conditions.

In 2009, the following diagnoses were confirmed by the treatment centers: 16 Phenylketonuria; 55 Congenital Hypothyroidism; 24 Galactosemia; 92 Sickle Cell Disease; 9 Congenital Adrenal Hyperplasia; 12 Amino Acid Disorders; 15 Acylcarnitine Disorders; 16 Biotinidase Deficiency and 62 Cystic Fibrosis Disease. The Amino Acid Disorders, Acylcarnitine Disorders, Biotinidase and Cystic Fibrosis statistics are from July 1, 2009 through December 31, 2009 reflective of Act 36 implementation. While 22 conditions were added for follow up, the analytes used in screening may be indicative of other conditions that the NSFP does not follow; therefore, they are "rolled up" into Amino Acid and Acylcarnitine disorders. The specific condition is confirmed during the confirmatory testing process and reported to the Bureau. Although Act 36 does not require follow up for Cystic Fibrosis carrier or other hemoglobinopathy traits, the NSFP coordinates the follow up process with the treatment centers to ensure that parents receive appropriate testing, counseling and education.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented Act 36 by developing a program to provide expansion of the of the Deaprtment's follow-up from 6 to 28 metabolic/genetic conditions.	X	X	X	
2. Coordinated statewide collection of a newborn screen bloodspot filter paper for 150,000 births a year.	X			
3. Contracted with two newborn screening laboratories to complete newborn screening on all newborns.	X		X	X
4. Assured case management in recommendations of referrals for confirmatory testing, assessment, and diagnosis.		X	X	X
5. Contracted with treatment centers to conduct case management, confirmatory testing, assessment and diagnosis and treatment.	X			
6. Revised current educational and outreach materials and developed new materials to address the implmentation of Act 36.	X			
7. Procured an integrated newborn screening data system to replace the current system and include expansion of follow-up for 22 additional conditions.				X
8. Collaborated with genetic/metabolic specialists to integrate a medical home model for newborns diagnosed with	X	X	X	X

metabolic/genetic conditions.				
9.				
10.				

b. Current Activities
The NSFP is currently working with the Technical Advisory Board on a number of areas: T4/TSH protocol, filter paper retention policy, severe combined immune deficiency (SCIDS), algorithm adjusting, and filter paper re-design. A medical consultant is also on contract to assist program staff establish medically sound guidelines associated with follow-up of the 22 supplemental conditions, as well as provide insight into unusual cases.

The NSFP administers a statewide metabolic pharmacy program that enables clients with PKU to obtain metabolic formula at their pharmacy. The NSFP works with the Departments of Aging and Welfare to broaden financial coverage of metabolic formula. The NSFP met with treatment center dieticians and physicians to review the formula application and renewal process and the metabolic formula formulary. Additions to the formulary will improve the dietary needs of the clients and increase compliance.

The NSFP is working with CF Treatment Centers to facilitate the referral process. A need to educate PCPs has been identified as many have never seen a CF client in their practice. PCPs also need education on carrier status and the importance of obtaining sweat testing at a laboratory accredited for this confirmatory test. Materials are being developed and the diagnosis process has been adjusted to help providers better serve clients with CF.

The NSFP anticipates that the newborn screening information system will be in place by the end of the year.

c. Plan for the Coming Year
The NSFP will monitor the national activity around SCID and other conditions and be prepared to address the potential integration of additional conditions into the Newborn Screening Program. Recently, the Secretary of Health and Human Services adopted SCID to the Recommended Uniform Screening Panel. The NSFP will also participate in the Secretary Sebelius' Advisory Committee on Heritable Disorders in Newborns and Children as appropriate.

The NSFP will intensify its educational and outreach efforts to meet the needs of stakeholders--hospitals, primary care physicians, coordinators, treatment centers and community health nurses. A multi-day conference is being planned for the Spring of 2011 to convene providers, partners and stakeholders from the hearing, metabolic and genetic services areas in order to strengthen medical home and foster collaboration between professions and services.

Increasing the treatment center capacity to provide specialized care, along with the integration of the use of a medical home to enhance treatment and care of children diagnosed with metabolic and genetic conditions will remain a priority. Ongoing will be the implementation of the reporting system and identified enhancements with the OZ system. This new data system will assist in the follow up process through case notes, letters generation and ultimately, electronic reporting. Increasingly, the Division of Newborn Screening and Genetics is working towards electronic notification and the use of secure email.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**145728**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	145367	99.8	17	16	16	100.0
Congenital Hypothyroidism (Classical)	145367	99.8	71	55	55	100.0
Galactosemia (Classical)	145367	99.8	38	24	24	100.0
Sickle Cell Disease	145367	99.8	95	92	92	100.0
Cystic Fibrosis	76809	52.7	81	62	62	100.0
Maple Syrup Urine Disease	145367	99.8	1	0	0	
Congenital Adrenal Hyperplasia (CAH)	145367	99.8	98	9	9	100.0
Aminio Acids (AA)	76809	52.7	33	12	12	100.0
Acylcarnitine (AC)	76809	52.7	24	15	15	100.0
Biotinidase (BIO)	76809	52.7	18	16	16	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	71	73	73	60.6
Annual Indicator	64.8	64.8	60.6	60.6	60.6
Numerator					
Denominator					
Data Source				See Field Level note	See Field Level note
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60.6	60.6	60.6	60.6	60.6

Notes - 2009
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available.
The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

Notes - 2008
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. Data for 2004 through 2006 identified the Core Outcome results from the State and Local Area Integrated Telephone Survey (SLAITS) conducted in 2001. Data for 2007 and 2008 is based on the 2005-2006 SLAITS.

Notes - 2007
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

a. Last Year's Accomplishments
Trainings on Tourette Syndrome were delivered to an additional 2, 843 professionals when compared to 2008. Partnering with families was evidenced at all levels of service provision by the contractor, from board meetings, conferences, to presence at a Legislative Breakfast.

The Division of Community Systems Development and Outreach (CSDO) System of Care Program (SOC) implemented a new structure during the 09-10 fiscal year, as the twelve Nursing Services Consultants (FHNSCs) were assigned to support the SOC Program following the end of the contract with Central Susquehanna Intermediate Unit. Continuity of efforts was important; therefore, the four component areas from the contract were transferred to the new management structure: community systems development (CSD) projects, community mapping, statewide initiatives (addressing respite, transportation, transition and inclusion) and outreach activities. The FHNSCs completed two community systems development projects, twelve outreach activities to reach CYSHCN and their families, mapped at least one county in each district and worked on each of the statewide initiatives. A SOC work plan was developed to guide the work of the Consultants with activities and measures for each area and more detailed work plans were created for the statewide initiatives. A SOC toll free line was added to the Health and Human Services Call Center to assist individuals in connecting with a Consultant. Families throughout the state received information about opportunities: program planning, input on policies, parent leadership trainings, advocating, and leadership roles on local, regional and statewide levels. This continues in the current year. A SOC web portal was rebuilt and launched to provide information about the program as well as a growing selection of community resources, and targeted outreach materials were developed and distributed.

CSDO kicked off the State Implementation Grant (SIG) for Integrated Services for Children with Special Health Care Needs. A meeting was convened with discussion focusing on four key areas: Home and Community Systems, Insurance, Medical Home and Transition. Parent input

was assured by hiring a parent of a child with special health care needs. Input was gathered from over 100 parents, youth and professionals who worked in topical and regional groups to identify strengths, areas of growth, and gaps in systems and service delivery.

PYPFs were established across the state with parents partnering with youth and providers to discuss issues. One action taken to address the theme was the coordination of a conference call for PYPF participants across the state about available resources such as the Special Kids Network.

CSDO established a mechanism for capturing the youth input with the hiring of a Youth Coordinator, who has special needs. Two Youth Development Institutes (YDLI's) for approximately 50 youth with special needs were held. These Institutes focused on engaging youth in leadership skill building, self advocacy and in helping them find their public voice.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided families information about and referrals to quality services for CYSHCN.		X		X
2. Supported community-based development and enhancement of services for CYSHCN.		X		X
3. Conducted Medical Home training of pediatric practices.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A CSD project brought over 100 volunteers to construct an accessible playground in southeast PA in seven days. Collaborative efforts to meet families' needs include work with the ARC of PA, the Parent Education Network, The Disabilities Rights Network, PA Developmental Disabilities Council, and the PA Association of Community Health Centers. The role of parents is also stressed for State Leadership Team on Transition, State Leadership Team for SpecialQuest, and PA Cares.

Increased prevalence of TS diagnosis has led to a significant increase in advocacy, in-service, outreach, and educational programs. PATSA continues to provide Consultant Services to school districts as they proactively seek to meet the needs of children with TS. The website, www.patsainc.org, is becoming a resource for Pennsylvanians living with TS as well as those interested in learning more about TS. This year, 54 new clients mentioned the website as their one-stop resource for information, a 17 % increase over last year's 46, prompting site renovations.

The PYPFs are continuing with parent leaders being identified and trained to assume leadership roles. Family Gatherings have also been developed to bring minority and underserved families and caregivers together to network and share their input relative to CYSHCN. To date 91 families have participated in six Gatherings. As a result, family participation in the regional PYPFs has increased by 40%.

c. Plan for the Coming Year

As the SOC Program implements changes that incorporate the strengths of the Consultants, the reach of the program is expected to expand as experience is gained and others continue to learn of its work. Community mapping will be a major area of growth. A capacity for electronic submission of mapping results was added to the web portal in mid 2010, allowing real time work to be completed and to continue to provide more resources to families and providers. The community mapping component includes opportunities for family input and leadership, and the work will also inform the Special Kids Network help line of additional resources for its database. Functions of the web portal now include a searchable resource database, a calendar of events (local and statewide), and links to other sites and publications. Through the statewide Respite initiative, families will continue to provide input for PA's application for federal lifespan respite funding. An ongoing goal of community systems development projects is to systematize them by replication. Work of the statewide initiatives has systemic implications as well, as Pennsylvania applies for federal respite funds and creates a collaborative and comprehensive approach to respite services across the lifespan. Efforts to improve transportation for CYSHCN in school districts will also continue, inclusion work will draw in faith based communities, and transition efforts will focus on improving the healthcare knowledge of youth and young adults achieving independence. Outreach will also be expanded as connections are made with others, and as the program continues to engage new resources (for example, the Office of Long Term Living which provides services for adults with disabilities).

Plans will be to continue the work of the PYPFs, Family Gatherings and YDLI's beyond the duration of the State Implementation Grant (5/31/2011). Participants of the Forums, particularly parents, caregivers and youth will be elevated into more visible and sustainable leadership and advocacy roles. A process within the Bureau of Family Health through which issues from the Forums can be heard and addressed either directly by DOH or by bringing that issue to the appropriate agency will be implemented.

In 2011, the PATSA will continue to provide outreach and information services across the state. With new studies from the CDC's Morbidity and Mortality Weekly Report issued in June 2009 indicating that as many as three out of every 1,000 children between ages 6 and 17 in the United States are afflicted with TS, more information needs to brought to medical professionals, educators and families.

In the coming year, PATSA will review the possibility of online support groups for adults with TS. Online social networking sites such as Facebook, LinkedIN, and Twitter will be explored.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	52	53	54	54	45.8
Annual Indicator	51.2	51.2	45.8	45.8	45.8
Numerator					
Denominator					
Data Source				See Field Level note	See Field Level note
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45.8	45.8	45.8	45.8	45.8

Notes - 2009
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

Notes - 2008
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. Data for 2004 through 2006 identified the Core Outcome results from the State and Local Area Integrated Telephone Survey (SLAITS) conducted in 2001. Data for 2007 and 2008 is based on the 2005-2006 SLAITS.

Notes - 2007
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

a. Last Year's Accomplishments
One hundred seven practices have been trained to date in medical home principles through the Educating Practices in Community Integrated Care (EPIC IC) medical home program. Quality has been improved with almost half of trained practices continuing to participate in activities such as annual training conferences and monthly teleconferences.

The electronic patient registry has been enhanced with each participating practice identifying and including their population of children and youth with special health care needs (CYSHCN) to total 15,542 CYSHCN to date. Eight practices have been funded for targeted care coordination activities with a designated care coordinator identified in each to work on the identification of community resources, recruitment of parent partners and development of care plans in collaboration with the parents of CYSHCN in the practice. Sixty-seven parent partners have been identified, representing 17 practices across the state to date. Parent partners are parents of CYSHCN who agree to work with the practice to provide the parent perspective on adhering to the principles of family centered care and work with the medical home team to recommend and ensure changes are made. These parents also serve as a resource for other parents within the medical home and for others interested in learning more.

Two important issues for the medical home practices have been addressed: mental/behavioral health and serving children in foster and substitute care by holding statewide conferences on each subject with participation from the practice teams, parents, community resources/partners and from state agencies. The Pennsylvania Mental Health Work Group was established as a result of one of the conferences and members are addressing barriers in mental health services such as the communication between primary care physicians and mental health providers, access to mental health providers, transition of youth to adult health care and reimbursement for

services. Issues and challenges relative to providing health care services to children and youth in foster care in each region were identified. During the conference, participants met with their regional coordinator from the Office of Children Youth and Families (OCYF), the state office which has oversight for providers serving children in foster care.

A documentary video was created that included parents, providers, and care coordinators and highlighted the principles of medical home, benefits to practices who participate in the medical home program, the importance of care coordination and the role of parent partners on the practice team. Utilized the video during presentations and for recruitment activities when EPIC IC staff meet with practices; see www.pamedicalhome.org.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted Medical Home training of pediatric practices.				X
2. Contracted with multi-disciplinary specialty clinics to integrate a medical home model for children and adults served by the specialty clinics.	X			X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Following presentations on a various issues requested by those who have attended the Parent/Youth/Professional Forums, several issues have risen to the top and workgroups are beginning to be formed. Several parents joined nurse consultants and hosted a resource night in two regions of the state to bring both families and providers to a common setting and showcase resources in the community.

Work continues to increase the number of participating primary care practices adopting medical home principles with regional informational meetings being planned. Four additional practices were funded for targeted care coordination activities, bringing the total funded practices to twelve. Goals include expansion of patient registries, development of parent partners, and working with community resources. All active practices in the EPIC IC program are receiving yearly Practice Reports to evaluate their work and set new goals for the coming year. The Report focuses on the patient registry, medical home index scores, family medical home survey results, and a summary of an intensive care coordination study.

Efforts are ongoing to engage Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) located in the rural areas of the state to reach those that may be uninsured and are typically underserved. To date, ten FQHCs and three RHCs have been contacted.

c. Plan for the Coming Year

The vendor will actively recruit additional practices to become medical homes with particular concentration on underserved areas and Federally Qualified Health and Rural Health Centers. Follow-up will be conducted with practices participating in the regional recruitment meetings, assessing their interest in participation of the medical home initiative, and continuing the process of their involvement as applicable.

A unified medical home for children and youth with sickle cell disease will be piloted within two Sickle Cell Centers in the state whereby the patients would receive both primary pediatric care and hematologic care at those sites. Care coordination will be improved through the combined medical home efforts within the pilot and the experience will inform future collaboration with other Sickle Cell centers as well as other specialty clinics in the state so that all children will benefit from a medical home.

Funding will be provided for an additional four practices for care coordination by transitioning four practices funded in 2009 away from funding.

Parent partner development and participation will be increased at the practice level through the use of focus groups, personal invitation and resource nights, all successful methods in engaging parent support.

The understanding of 'medical homes' will be broadened by connecting EPIC IC staff and participants in the regional Parent/Youth/Professional Forums.

Data will be collected and analyzed including: use of the registry, medical home indexes, family surveys, Medicaid claims data, and outcomes of care coordination activities.

The EPIC IC website will be strengthened, particularly building the resource area and expanding the "Especially for Parents" area of the site.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	66	68	70	70	66.2
Annual Indicator	61.4	61.4	66.2	66.2	66.2
Numerator					
Denominator					
Data Source				See Field Level note	See Field Level note
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	66.2	66.2	66.2	66.2	66.2

Notes - 2009
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

Notes - 2008
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. Data for 2004 through 2006 identified the Core Outcome results from the State and Local Area Integrated Telephone Survey (SLAITS) conducted in 2001. Data for 2007 and 2008 is based on the 2005-2006 SLAITS.

Notes - 2007
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

a. Last Year's Accomplishments
The Health Care Hand Shake Agreement, combined with The Cover All Kids initiative, expanded enrollment for the Children's Health Insurance Program (CHIP) and Medical Assistance (MA) programs. The Handshake initiative that began in calendar year 2009 between the Pennsylvania Insurance Department and the Department of Public Welfare is a means to eliminate applications from getting lost in the eligibility determination process. For calendar year 2009, MA enrollment increased by almost 11% (1,097,750) over the previous calendar year (992,059); CHIP enrollment increased by 8% (197,150) over the previous calendar year (182,418).

The Health and Human Services Call Center (HHSCC) Information and Referral (I&R) Specialists are trained to ask callers if their children have health care coverage, specifically if the family has a child with a special health care need. During calendar year 2009, 842 Medical Assistance (MA) Applications were disseminated to helpline callers with a special need. 234 callers were referred to the local Social Security (SS) Office; 234 callers were referred to the Department of Health (DOH) Special Needs (SN) Unit; and, 413 individuals were referred to the local County Assistance Office (CAO).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contracted with multi-disciplinary specialty clinics to explore insurance products and identify the most appropriate product that will provide the greatest financial relief for children and adults served by the specialty clinics.	X	X		X
2. Provided information and referral services to screen and refer CYSHCN and their families for health care coverage.		X		X
3. Conducted Medical Home training of pediatric practices.				X
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2010, the Pennsylvania Insurance Department asked each of its ten insurance health plan contractors who are responsible for determining eligibility and enrolling children in CHIP to monitor their utilization information to identify current CHIP enrollees with special needs who may be eligible for comprehensive Medical Assistance (MA) benefits under Department of Public Welfare (DPW). If a health plan contractor identifies a CHIP child who may be eligible for MA benefits, the contractor will reach out to the child's family and work with the family and their health care providers to make a final determination as to which program, CHIP or MA, the child is eligible for. If the child is found eligible for Medical Assistance, the child will be transferred from CHIP to MA without a lapse in coverage.

c. Plan for the Coming Year

Department of Public Welfare (DPW) will improve the "Health Care Hand Shake Agreement" as new disparities are identified. Through a collaborative effort with the Health and Human Services Call Center (HHSCC), Pennsylvania Department of Aging, Pennsylvania Department of Public Welfare and the Pennsylvania Insurance Department, a professional facebook page has been implemented. The page will capture program and agency highlights, discussion topics, "did you know" themes and an event calendar. This creates an additional venue for the public to access information and resources and to "spread the word" about program services. Links, open forum questions and photos can be added to the page to make it more attractive. HHSCC began posting program information May 2010. Facebook has the capability to track the number of visitors to the page.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	80	82	89.5	89.5
Annual Indicator	73.4	73.4	89.5	89.5	89.5
Numerator					
Denominator					
Data Source				See Field Level note	See Field Level note
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	89.5	89.5	89.5	89.5	89.5

Notes - 2009
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

Notes - 2008
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. Data for 2004 through 2006 identified the Core Outcome results from the State and Local Area Integrated Telephone Survey (SLAITS) conducted in 2001. Data for 2007 and 2008 is based on the 2005-2006 SLAITS.

Notes - 2007
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

a. Last Year's Accomplishments
The Special Kids Network System of Care (SOC) implemented a new structure under the direct administration of the Department of Health in July 2009. With the close of the contract, two FTE program administrators from the Department of Health were retained for the administration of the program, and twelve regionally based Family Health Nursing Services Consultants were brought on board to support the program as a portion of their work responsibilities.

Administrators developed SOC work plans to guide the work of the Consultants. Four component areas from the contract were retained in the new structure: community systems development projects, community mapping, statewide initiatives (addressing respite, transportation, transition and inclusion) and outreach activities. Consultants implement a minimum of 12 community systems development projects, 72 outreach activities targeted towards CYSHCN and their families, mapping of six counties and work in each of the areas of the statewide initiatives. Additionally, an SOC toll free line was added to the Health and Human Services Call Center (HHSCC) to assist individuals in connecting with a Consultant. The SOC web portal was improved to provide information about the program and to be another source of community resources for families and providers. Efforts to bolster outreach activities included development of standardized materials for distribution, a more systematic approach to targeting events, and the broadening of statewide outreach.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted Medical Home training of pediatric practices.				X
2. Worked within the community to assure services are delivered in a manner that is accessible to families in need of them.				X
3. Contracted with local health departments to provide information and referral on available community resources and link families to appropriate settings.	X	X	X	X

4. Contracted with multi-disciplinary specialty clinics to insure case management and care coordination for children and adults served by the specialty clinics.		X		X
5. In a systematic fashion, mapped services within communities and made the resulting information available to families.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborative efforts with organizations like the ARC of PA, Parent Educational Network, Disabilities Rights Network, and PA CARES Task Force are building mutual awareness of programs and services for families. The State Leadership Team on Transition strengthens state agencies in collaborating to assist transitioning youth. The Team is drafting a new Memorandum of Understanding to guide its work now and through the change in state governance. Locally, Consultants are involved in over 90 local and regional committees including Local Interagency Coordinating Councils, secondary transition councils, school districts, health improvement coalitions, and children's teams that focus on addressing gaps in services, and better systems for serving children.

Meeting the needs of teenage girls interested in attending their prom connects faith based organizations with students with special needs in local high schools in northwest PA. In this replicable project, the girls found prom gowns, were provided with a makeover and information about programs and resources. SOC administrators are collaborating to improve respite services statewide, including applying for federal funds to support the efforts and in revising the Transition Health Care Checklist. Connecting systems serving families in the military is another example of strengthening systems.

c. Plan for the Coming Year

A major area of growth for SOC will be in the community mapping component. Expanded mapping activities to document resources in at least six counties will serve not only as a source of information for families and providers but will also set the stage for facilitative work with communities to assist them in exploring their assets and gaps and in creating a plan to address those gaps. Work on inclusion in early childhood settings is expanding to encompass promoting inclusion and ways to work with CSHCN in professional development settings, from college level to existing practitioners. If funded, Pennsylvania will be creating its first lifespan respite care system to better coordinate and collaborate across public and private institutions and with different funding sources and programs. Focus for the Nurse Consultants will include systematizing initiatives. This includes initiatives such as transition related Mentoring Days to organize student placements with community business mentors and provide a ‘real' world experience as the students transition into adult living. The SOC mapping activity will continue to support the HHSCC's database development through the transition to a new contract after February 2011.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective	34	36	38	48	46
Annual Indicator	5.8	5.8	46	46	46
Numerator					
Denominator					
Data Source				See Field Level note	See Field Level note
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46	46	46	46	46

Notes - 2009
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. The annual performance objective for this measure has been set to match the annual indicator from 2006, which reflects the results of the latest (2005/2006) National Survey of Children with Special Health Care Needs (CSHCN), and will remain at that level until another CSHCN survey is conducted.

Notes - 2008
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Numerators and denominators are not available. Data for 2004 through 2006 identified the Core Outcome results from the State and Local Area Integrated Telephone Survey (SLAITS) conducted in 2001. Data for 2007 and 2008 is based on the 2005-2006 SLAITS.

Notes - 2007
Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

a. Last Year's Accomplishments
SOC was involved in improvements to the Memorandum of Understanding Shared Agenda on Transition, through which the Pennsylvania Departments of Education, Health, Labor and Industry and Public Welfare have committed to work in equal partnership to support youth with disabilities who are transitioning into adult life in the achievement post-school outcomes. The agencies implemented wording solidifying the involvement of families and youth with special health care needs within policy and program planning. As this document will be presented to the next administration, it was imperative that the commitment to including those being served was included and agreed upon by agency representatives.

The 2009 Pennsylvania Community on Transition Conference "Success by Design" was held from July 22, 2009 to July 25, 2009. The richness and diversity of "Success by Design" was expanded by the commitments of multiple departments, agencies and partners within the Pennsylvania Transition Community of Practice, and the nearly 800 registrants for the conference, including a much stronger contingency of youth and families than the previous year.

The Department of Health staff, Program Administrators and Family Health Nursing Services Consultants alike contributed through their involvement in event planning and presentations.

The SKN SOC has implemented activities through which transition resources and tools, as well as outreach materials that assist CYSHCN, their families, and community based service providers access services, are provided through the Bureau of Family Health and other agencies. Through the Health and Human Services Call Center and the Special Kids Network System of Care web portal, tools such as the Transition Health Care Checklist and the newly developed Special Kids Network System of Care Outreach Folder have been made available with a greater level of coordination and ease of access. In addition to increased SOC outreach efforts and trainings, more than 1200 Transition Health Care Checklist and 1250 SKN SOC folders were distributed.

Transition, particularly the transition from pediatric to adult health care providers, was addressed within the work of the State Implementation Grant for Integrated Services for Children with Special Health Care Needs (SIG). A Transition Learning Collaborative (TLC) was created as an opportunity for stakeholders of the educational, medical and community based services systems to discuss and address issues that will ensure that youth with special health care needs make successful transitions to all aspects of adult life. Work of the TLC began by identifying key stakeholders, including parents and youth, and gathering their input to design the framework for the work of the collaborative. Stakeholders from other statewide and local transition efforts such as the State Leadership Team on Transition were included to ensure that the TLC would support but not duplicate other work occurring around transition. Health related presentations were included into the current educationally based statewide Transition Conference to broaden the understanding of transition. The Conference was marketed to Medical Home practices with the goal of them attending and interacting with families and other service systems. Planning began to pilot three best practice models for transition in 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted Medical Home training of pediatric practices.				X
2. Co-sponsored the annual Transition Conference, facilitating transition to adulthood for YSHCN in attendance.		X		X
3. Participated in MOU Shared Agenda on Transition to create pathways to adulthood for YSHCN in all aspects of adult life; health, education employment, housing.		X		X
4. Contracted with multi-disciplinary specialty clinics to provide the case management and care coordination necessary for children and youth served by the specialty clinics transition to adult health care.	X	X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SOC has a primary role in the planning of the 2010 Pennsylvania Community on Transition Conference "Empowerment in Action: a Unified Approach." The SOC Administrator was responsible for including a health track. The Transition Conference includes seventeen workshops and two feature presentations focusing on health related transition issues. Approximately 30 medical home practice staff are anticipated to participate.

The SOC administrators as well as several Nurse Consultants have been involved in the Transition Learning Collaborative that is part of the State Implementation Grant. Recommendations will be forwarded to the Department of Health particularly regarding health issues and to strengthen transition planning.

The Department of Health's Transition Healthcare Checklist is being updated. This document presents cross systems health related information to transitioning youth and their families and serves as a model for other states.

A parent of a child with special health care needs was hired to coordinate the TLC. Work is in four areas: Resource Identification, Integration of Disciplines, Medical Provider Issues and Youth Wellness/Self Advocacy. In addition, three best practice transition models focusing on workforce development, building of strong partnerships between health care and community partners and the use of transition care plans are being piloted.

c. Plan for the Coming Year

SKN/SOC will expand its provision of transition resource material and tools to children and youth with special health care needs, their families and community based service providers with a greater level of coordination and ease of access on the SKN/SOC web portal. SKN SOC will continue to make the Transition Health Care Checklist available through all outreach events and trainings, as well as on the web. The Checklist is a print resource to help youth/young adults with special health care needs make a successful transition to adult living that includes their health and health care.

Acceptable recommendations made to the Department by the four Transition Learning Collaborative multidisciplinary work groups will be analyzed for implementation on the topics of: Resource Identification, Integration of Disciplines, Medical Provider Issues and Youth Wellness/Self Advocacy. For instance, the Medical Provider Issues workgroup will provide recommendations on preparing a grand rounds presentation on transition that can be delivered in hospitals across the state for joint grand rounds with pediatric, family medicine and internal medicine. The recommendations will be shared with other groups working on transition as well, especially for issues needing to be addressed outside of the Department of Health. Information gleaned from the work of these groups will be shared with the three existing best practice transition pilots for potential inclusion in their work as well as with other groups working on transition such as the State Leadership Team. The outcomes of the work groups and the transition pilots will be presented at the statewide transition conference in 2011. The TLC will collaborate with the Philadelphia Department of Public Health Special Needs Workgroup to support a survey of adult clinicians in southeast Pennsylvania to assess referral sites for children with special health care needs who are transitioning to adult medical providers. The survey will be replicated if successful, with adult clinicians throughout the rest of the state.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	87	87	87	85	85
Annual Indicator	83.2	84.6	81.4	80.4	
Numerator					

Denominator					
Data Source				See Field Level Note	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	80	80	80

Notes - 2009
Data for 2009 will not be available until later in the year 2010

Notes - 2008
The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available.

Data should be in this form:
2005: 83.2+/-5.2
2006: 84.6+/-4.4
2007: 81.4+/-4.1
2008: 80.4+/-4.9

Notes - 2007
The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available.

Data should be in this form:
2004: 85.7+/-4.0
2005: 83.2+/-5.2
2006: 84.6+/-4.4
2007: 81.4+/-4.1

a. Last Year's Accomplishments
According to the National Immunization Survey for 2008, 80.4% of 19 to 35 months old in Pennsylvania received 4 doses of a DTP vaccine, 3 doses of polio vaccine, 1 dose of measles/mumps/rubella vaccine, 3 doses of haemophilus influenzae type B vaccine and 3 doses of hepatitis B vaccine. The annual performance objective of 85% for 2008 was not met. The percent of 19 to 35 month olds who have received a full schedule of age appropriate immunizations has shown a decrease over the past three years, 2006 (84.6%), 2007 (81.4%), 2008 (80.4%).

The main focus of the Division of Immunization is to eliminate or control vaccine-preventable diseases. Vaccines are provided to public and private health care providers for infants, children, adolescents and adults to protect against diseases such as measles, diphtheria, tetanus, pertussis (whooping cough), polio, mumps, rubella (german measles), hepatitis A, hepatitis B, influenza, haemophilus influenzae type b, pneumonia, varicella (chickenpox), meningococcal, human papilloma virus and rotavirus.

A hospital based hepatitis B birth dose program, Tot Trax, currently has 92 out of 98 birthing

hospitals throughout the Commonwealth participating in the program. Of those participating, 100% utilized Department supplied hepatitis B vaccine to immunize their newborn prior to discharge. The program added Tdap vaccine in 2009 for administration to all new mothers to meet the CDC recommendations for Pertussis immunization.

The Division of Immunizations continues to offer opportunities for Pennsylvania school-aged children to obtain the required immunizations during school-based clinics. Schools had the opportunity to offer hepatitis B, tetanus/diphtheria acellular pertussis (Tdap), meningococcal (MCV4) and varicella vaccines to school based clinics for the 2009-2010 school year.

Annually, each public and private school in Pennsylvania is required to report the immunization status of their students. The report is antigen specific and only for kindergarten and seventh grades for both public and private schools for the 2009-2010 school year. 89% of students were in compliance with all immunization requirements. Down from 97% in 2008. 8.18% were provisionally enrolled, an increase from 1.5% in 2008 and .84% were medically exempt, an increase from .37% in 2008, and 1.73% claimed religious exemption, an increase from 1.19% in 2008.

Annually, Childcare Group Settings are required to report immunization histories for children in their facilities. This requirement coincides with Pennsylvania's Department of Public Welfare's licensure requirement that children in licensed childcare facilities are appropriately immunized. In 2008 approximately 4,286 childcare group settings were required to report immunization histories for the children attending their facilities. Compared to 2007 data there was a 4.5% decrease in non-reporting Child Care Groups Settings; however coverage levels fell by at least 4.5% in the reporting areas.

The development, implementation and expansion of Pennsylvania's Statewide Immunization Information System (SIIS) serves as a vehicle for monitoring, tracking and accounting for more than 2 million doses of vaccines on an annual basis among nearly 1,700 provider sites.

The statewide Pennsylvania Immunization Coalition (PAIC) and the network of county specific and regional coalitions actively promoted, strengthened and expanded Pennsylvania 17 local coalitions which service 48 counties.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analyzed immunization histories for children in Childcare Group Settings.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During March 2010, National Infant Immunization Week tool-kits were developed and distributed to all Department District Offices and County Municipal Health Departments. At least one outreach activity for minority, disparate, or underserved children was developed in each area.

c. Plan for the Coming Year
In 2011 the program will be launching the Vaccine Tracking System (VTrckS), a critical component of the Vaccine Management Business Improvement Project (VMBIP), which is an information technology system that will integrate the entire publicly-funded vaccine supply chain from purchasing and ordering to distribution of the vaccine. VTrckS will allow health care providers to input their vaccine requests (orders) directly online thereby improving efficiency and accountability of public dollars. The system will evaluate vaccine orders against specific guidelines set by grantees (i.e., state, local, and territorial health departments) and the Centers for Disease Control and Prevention.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	13	12	15.3	15.1
Annual Indicator	15.4	16.0	16.1	16.3	
Numerator	4162	4313	4313	4269	
Denominator	269471	270122	267102	262295	
Data Source				See field level note	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14.9	14.9	14.7	14.7	14.7

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

a. Last Year's Accomplishments
The 2008 annual indicator was 16.3 births per 1,000 for teenagers aged 15 through 17 years of age. The annual performance objective of 15.3 was not met. The birth rate for teenagers aged 15 through 17 has been slowly increasing over the past four years which demonstrates the need for comprehensive pregnancy prevention programs. The Division of Child and Adult Health Services formed a team with the Pennsylvania Department of Education (PDE), the Center for Schools and Communities, and the Family Health Council of Central Pennsylvania, Inc. (FHCCP) to apply for the Association of Maternal and Child Health Programs (AMCHP) sponsored Preconception

Health for Adolescents Action Learning Collaborative (ALC). The PA team was one of six teams selected to participate in this ALC. The goals of the ALC project are: Parents and primary care givers are fully informed about the stages of adolescent development and have the associated communication skills, Increase the awareness of the Lifespan Approach to primary care providers, and Increase the awareness of the Lifespan Approach to school based health educators. Implementation of this project will occur in SFY 2009-10.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Served as a board member on the Pennsyvlania Coalition to Prevent Teen Pregnancy.				X
2. Maintained and updated the SAFETEENS website.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Division of Child and Adult Health Services continues to work with the Preconception Health Team to reach the goals listed above. The Division will facilitate a stakeholder meeting to discuss parent education modules and best practices in parent education with the outcome of modules being developed that can be woven into existing parent education programs throughout the Commonwealth. In addition, webinars for educators and primary care providers on the Lifespan Approach will be developed and held to reach the goal of increasing the awareness. For additional activities please see State Performance Measure 9.

c. Plan for the Coming Year

The Division of Child and Adult Health Services will continue to coordinate the Preconception Health Team to increase awareness of the Lifespan Approach and to develop best practices around preconception health for adolescents. For additional activities please see State Performance Measure 9.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	38	38	38	30	26
Annual Indicator	25.3	29.5	25.8	25.8	28.6
Numerator	11510	13895	15248	15248	17984
Denominator	45576	47061	59114	59114	62815
Data Source				See Field Level Note	See Field Level Note
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27	27.5	27.5	28	28

Notes - 2009
Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/09 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/09.
Source: PA Department of Public Welfare

Notes - 2008
Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/08 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/08.

Source: PA Department of Public Welfare

Annual Performance Objectives changed from prior years to reflect current trending.

Notes - 2007
Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/08 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/08.

Source: PA Department of Public Welfare

a. Last Year's Accomplishments
The percent of third grade children who have received protective sealants on at least one permanent molar tooth increased from 25.3% in 2005 to 28.6% in 2009, exceeding the annual performance objective of 26.0 for 2009. However, the 28.6% in 2009 was a 3% decrease from the 29.5% in 2006. Even though the number of third graders served each year continues to go up, the decrease in percent could be due to the increase in the denominator (the number of children eligible for this service). One explanation is the direct result of limited financial and workforce resources to provide access to dental sealants for underserved and underinsured children. Additionally, there are inherent challenges in effectively providing school-based dental sealant programs, such as the requirement for parental consent, anticipatory guidance, scheduling conflicts with school activities, and students' perceptions of such a program as a program for low-income individuals.

The Healthy People 2010, Objective 21-8, goal is to increase the proportion of 8 and 14 year olds with at least one dental sealant to 50 percent. The Department's Oral Health Needs Assessment (OHNA 2000) found that approximately 25 percent of 8 and 14 year olds in Pennsylvania have at least one dental sealant. In 2008-09 the Department funded 3 school-based dental sealant programs at the Allegheny County Department of Health, Chester County Health Department, and the York City Department of Health to expand the availability and accessibility of this important preventive oral health measure. Program efforts provided funding to acquire appropriate equipment and organize outreach at schools with at least 50 percent enrollment of students in the Free and Reduced Cost School Meal Program. Sealant programs were conducted by 3 grantees and a total of 3,736 sealants were placed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Funded 3 school-based dental sealant programs to expand the availability and accessibility of oral health.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2009-10, funding for the school-based dental sealant programs has been continued to the 3 grantees. Approximately 2,400 students are expected to participate. In addition, the Department will continue to utilize the Sealant Efficiency Assessment for Locals and States (SEALS) data collection program.

c. Plan for the Coming Year

Pending available funds, the Department will continue the school-based dental sealant programs in 2010. It is estimated that grantees will maintain a level of 2,400 students participating.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	2.5	2.4	2.3	2.3	2.3
Annual Indicator	2.3	2.9	2.2	1.4	
Numerator	54	66	50	32	
Denominator	2326570	2313503	2299158	2290858	
Data Source				See Field Level Note	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.3	2.3	2.3	2.3	2.3

Notes - 2009

Data not available. Usually these data are available 12 to 18 months from the close of teh calendar year.

Notes - 2008
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

a. Last Year's Accomplishments
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes decreased from a high of 2.9 in 2006 to 1.4 in 2008, surpassing the 2008 annual performance objective of 2.3. The decrease in deaths to children 14 years and younger caused by motor vehicle crashes may be attributed to Pennsylvania and its injury prevention partners' continuing efforts in conducting child passenger safety events each year. At these events, child safety seats are checked for proper fit and installation by certified child passenger safety technicians.

In support of child passenger safety, Safe Kids PA Coalitions and Chapters conducted 336 child safety seat events during 2009. At these events 3,761 child safety seats were checked for proper fit and installation. A total of 945 child safety seats were distributed by the chapters and coalitions to families in need through these events. In addition, Safe Kids PA affiliate child passenger safety permanent fitting stations conducted 3,081 car seat inspections and distributed 831 new seats.

During SFY 2008-09, Safe Kids PA Coalition provided technical assistance and training to 49 local coalitions and chapters through site visits, telephone technical assistance, distribution of injury prevention materials, and three statewide meetings. In addition, it sent two editions of the Safe Kids PA Coalition newsletter to 1,450 injury prevention partners across the state. The three statewide meetings were held in November, March and June and approximately 60 persons were in attendance at each of the meetings. In addition, Safe Kids PA hosted three Elluminate(r) web based classroom trainings addressing: Baby Safety, Child Passenger Safety, and Water Safety issues. These trainings are available for all Safe Kids coordinators, affiliate members, and the advisory council. Approximately 104 persons total participated in these three trainings.

The Safe Kids PA Coalition attended a multitude of public events that were held throughout the year and provided educational materials to the public. Some of these events included: Pennsylvania State Farm Show; Play Safe Be Safe Workshop, Law Enforcement Seminar, NHTSA Region 2 Child Passenger Safety Conference, Child Passenger Safety Technician Courses as Instructor (5 courses), Lifesavers Conference, as an exhibitor at the following conferences: The American Trauma Society, PA Division, Promising Practices, Safe Schools, Special Needs Transportation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted infant safety seat events checks.			X	
2. Conducted child passenger safety technician courses and refresher courses.				X
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2008-09, a total of 33 Safe Kids PA Coalitions and Chapters were awarded with mini-grants. Of these grants, 5 smoke alarm grants, 11 child passenger safety seat grants, 10 portable cribs grants, and seven bike helmet grants. In addition, 12 Bicycle Safety grants were also provided.

In order to increase the amount of funds available to support local prevention programs through Safe Kids affiliates, the Department will directly administer mini-grants to the affiliates, not through Safe Kids PA. Beginning in July 2010, the Safe Kids PA Coalition will only provide web-based technical assistance, arrange and deploy an annual childhood safety conference, and coordinate the annual outreach to rural families through the Pennsylvania Farm Show exhibit area.

c. Plan for the Coming Year
Safe Kids PA will continue to seek new lead agencies for chapter formation in counties without a Safe Kids presence. Safe Kids PA will continue to partner with Child Death Review to develop prevention projects in the local communities according to need. The Central Susquehanna Intermediate Unit, the lead agency for Safe Kids PA, will work to identify new resources for statewide efforts.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	38.5	40	40	37.5
Annual Indicator	37.5	35.8			
Numerator					
Denominator					
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37.5	37.5	37.5	37.5	37.5

Notes - 2009
2007 birth data should become available in 2010/2011. Data delay as CDC is developing a new system of data collection by year of birth. These data are collected over a 3-year period and final data are available 4 years from date of birth.

Notes - 2008
The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Center for Disease Control and Prevention. Numerators and denominators are not available.
Data should be in this form:
2005: 37.5 +5.2
2006: 35.8+5.5 - Provisional Data

Notes - 2007
2006 birth data should become available in 2009/2010. Data delay as CDC is developing a new system of data collection by year of birth. These data are collected over a 3-yr period and final data are available 4 yrs from date of birth.

The Annual Indicators were obtained from the National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Numerators and denominators are not available.

Data should be in this form:
2004: 32.7+/-4.9
2005: 37.5 +/-5.2

a. Last Year's Accomplishments
The Breastfeeding Coordinator worked with a team of members from the Pennsylvania Breastfeeding Coalition to develop a grant application to support breastfeeding women in the workplace. The State Department of Health now offers 2 places for mothers to breastfeed while at work. This activity is in concert with the Freedom to Breastfeed Act of 2007.

The Breastfeeding Coordinator worked with her counterpart in WIC to develop and implement a statewide mandatory training program for all WIC agency personnel in preparation for the upcoming changes in the food packages that took effect on October 1, 2009. They developed written materials and visual aides and other consumer materials to clarify the different food package content if breastfeeding exclusively, partially, or not at all. They developed eight self-teaching modules to explain the food package changes for the local WIC staff and ensured that all staff were trained on the breastfeeding counseling protocol. To improve the breastfeeding curriculum, they designed training programs as part of an ongoing statewide objective that would address cultural barriers that deter women from breastfeeding and from discontinuance like a fussy baby. An additional 30 staff became certified as Happiest Baby instructors to help address the issue of duration. This brought the total to 215 WIC staff currently certified.

Despite these efforts, the last available data for this performance measure (35.8 percent in 2006) did not meet the annual performance objective of 38.5 percent. New data from the National Immunization Survey for year 2007 are currently not available.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted WIC annual training of all new professionals on breastfeeding support techniques and resolution of problems				X
2. Developed and distributed public education resources				X
3. Promote breastfeeding and support practices through presentations at hospitals, physician offices, and other public places				X
4. Evaluating data based on a geographic focus to assess where activities/intervention is necessary				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Demand for the use of the Mom's Room's continues to grow and records indicated that the rooms have been used a total of 1080 times during the past year.

Title V staff collaborated with the DOH Wellness Committee which led to a partnership on a pilot project that educated physicians on the benefits of breastfeeding. The project funded several teams of professionals that traveled to 70 practices throughout the Southeastern and Southwestern areas of the state. These areas were chosen due to low breastfeeding rates. The original goal of "50 practices" was met with a waiting list requesting presentations.

Funding for the USDA Peer Counselor Program was increased which allowed PA WIC to expand this service to four more agencies. Currently existing programs are expanding the number and/or hours of their peer counselors. There are now a total of ten local agencies with Peer Counselor Programs. Additionally, the PA WIC Program increased funding for breast pumps to WIC local agencies by 38% from $454,500 in FFY 2009 to $628,289 in FFY 2010.

c. Plan for the Coming Year
To make a significant change in the duration rates, the BFH needs to complete a more in depthy analysis on the reasons why women are failing to continue to breastfeed when they return to work. This analysis will be part of the breastfeeding strategic plan.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98.3
Annual Indicator	98.0	98.0	98.1	97.2	97.6
Numerator	138495	141791	143353	140487	138427
Denominator	141341	144749	146191	144564	141794
Data Source				See Field Level Note	See Field Level Note
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	98.4	98.5	98.6	98.7	98.7

Notes - 2009
Numerator source: Division of Newborn Screening and Genetics
Denominator source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2008
Numerator source: Division of Newborn Screening and Genetics
Denominator source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Numerator source: Division of Newborn Screening and Genetics

Denominator source: PA Department of Health, Bureau of Health Statistics and Research

a. Last Year's Accomplishments
In calendar year 2007, 143,353 infants were screened before hospital discharge and 94% passed their initial screening, 6% needed a re-screening and 5% received a re-screening.

A hospital workgroup was formed in calendar year 2009 to engage collaboration and begin the process of researching and developing best practices to share with all hospitals and incorporate into the Program Guidelines. Ten portable hearing screening units were purchased for the out of hospital hearing screening program to improve the quality and reliability of screens. These new units were distributed throughout our midwife network to screen infant born in an out of hospital setting for hearing loss. Program staff reviewed the use of the equipment, reporting requirements and the development of informational materials to encourage screenings for families that traditionally refuse hearing screening. The BFH has contracted for a new newborn screening data system. This new data system will assist in the follow-up process by organizing the communications with our providers and families, through case notes, letters generation and ultimately, electronic reporting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided technical support to hospitals to administer pass/fail hearing screenings.			X	
2. Provided technical support to pediatric audiologists to administer diagnostic exams.	X			
3. Conducted follow-up contact to Primary Care Physicians (PCP) and familiy for futher appointment and diagnosis information.	X			
4. Referred newborns to early intervention services, hearing aids, sign language.	X			
5. Provided PCP education on newborn hearing screening diagnostic protocols and early intervention coordinator education.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Following the work of the Hospital workgroup, a statewide hospital teleconference is planned. Enhanced technical assistance to hospitals is scheduled for the remainder of 2010. A Midwife meeting is planned for fall of 2010 to improve relations with our Out of Hospital Hearing Screening Program Provider and discuss their concerns and issues with the program as well as receive information on other bureau programs. Program will continue working with OZ Systems on the development and implementation of the new data system for the Metabolic Screening program and the Hearing Screening Program. The DOH is using HL7 messaging for sending metabolic lab results from the participating laboratories to OZ systems. This innovative messaging has been challenging in that, new codes from the national level needed to be developed throughout this process making it more lengthy than anticipated. However, being the first program in the country to complete this joint system using HL7 messaging will make future messaging easier.

c. Plan for the Coming Year

NSGP plans to formalize the best practices identified through the enhanced technical assistance for hospitals project. This includes on site visits, tip sheets with specific suggestions for screening and reporting improvements and financial assistance to purchase new hearing screening hospital units. This project will be made available if the DOH receives a HRSA Supplemental grant that was applied for in June of 2010. This grant will provide additional funds for specific projects to improve the program through August of 2012. The new hearing screening units will be compatible with the OZ system for electronic reporting. Oz is compatible with 23 different hearing screening unit manufacturers. This will allow hospitals to directly upload screening information from the units into the OZ data system so the Division will have individual screening information. Currently the DOH receives aggregate screening information that is hand tallied.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.2	9.2	9.1	7.3	7.5
Annual Indicator	8.3	7.3	7.5	6.7	
Numerator	235000	203000	207000	185000	
Denominator	2830000	2778000	2775000	2775000	
Data Source				See field level note	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6.7	6.7	6.5	6.5	6.5

Notes - 2009

Data not available. The U.S. Census Bureau data for 2009 will not be available until September 2010, so there will be a gap in our reporting on these figures.

Notes - 2008
Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us.

Notes - 2007
Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us. The U.S. Census Bureau data for 2008 will not be available until September of 2009, so there will be a gap in our reporting on these figures. The data for year 2004 were revised based on improvements to the algorithm that assigned coverage to dependents, and there was an adjustment to the weights.

a. Last Year's Accomplishments
The 2008 performance objective for this measure was set at 7.3 percent. Data from the US Census Bureau showed that 6.7 percent of children in Pennsylvania did not have health insurance, therefore exceeding the target. Data show there has been a steady decrease in the percent of children without health insurance.

In February 2009, additional changes to the CHIP program were effected by the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA reauthorized the program, add mechanisms for federal funding, and established many new requirements for the program. The CHIPRA requirements that received the most attention at the federal level in 2009 were:

- Citizenship and Identity Verification
- Express Lane Eligibility/Administrative Simplifications
- Choice of Managed Care Organizations
- Payments to Federally Qualified health Centers and Rural Health Centers
- Provision of Information about Dental Providers on the Insure Kids Now Web site
- Mental Health Parity

Calendar year 2009 afforded the Department many opportunities to work with advocates, insurers, community partners, legislators, and other stakeholders to make health insurance available and accessible to Pennsylvania's uninsured children and to begin the processes necessary to comply with CHIPRA. It was the second full calendar year in which the Cover All Kids expansion to eligibility was in effect. In the 2009 federal fiscal year, CHIP enrollment increased from 178,018 to 195,932.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contracted with multi-disciplinary specialty clinics to explore insurance products and identify the most appropriate product that will provide the greatest financial relief for children and adults served by the specialty clinics.	X	X		X
2. Provided a venue for eligibility screening, and referral of children and families to healthcare coverage.				X
3. Tested the "Health Care Hand Shake" to make referrals between CHIP and Medical Assistance.		X		
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2010, the Department of Insurance coordinated with partners and CHIP contractors statewide to provide outreach events during Cover the Uninsured Week. A "Tell a Friend" CHIP flyer that encourages people to pass the information about CHIP onto someone they know who may need health insurance for their children was developed. In addition, CHIP celebrated its' 18 birthday.

The CHIP recently conducted a "phone break" with the CBS TV affiliate in Philadelphia, promoting CHIP and encourage viewers to call the toll free CHIP helpline to apply.

The CHIP continues to co-chair the nationally recognized "Reaching Out Interagency Workgroup" composed of state agencies, community-based organizations and advocacy partners.

This spring, 2.2 million CHIP flyers were mailed to every public intermediate school in PA for distribution to every student at the beginning of next school year. Simultaneously, this information was e-mailed to every public school and many private and charter schools, making them aware of the program.

The CHIP served as a co-sponsor of the annual PA PTA convention that drew PTA representatives from across the state. CHIP worked with the Health and Human Services Call Center to create a PA health and human services "Help in PA" Facebook page to further disseminate information about CHIP and other social service programs to a new, broader audience. CHIP enrollment has increased in the 2010 federal fiscal year to 197,986 as of May 2010.

c. Plan for the Coming Year
Although not yet approved by the state legislature, the Governor's proposed budget for the 2010-11 state fiscal year would allow for further increases in CHIP enrollment in the 2011 federal fiscal year. A strategic marketing and outreach plan will be established and put into place for CHIP after it is known what the upcoming FY budget provides for the program.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.9	13.8	13.7	13.6	13.5
Annual Indicator	25.0	24.7	24.2	25.8	26.8
Numerator	25787	25570	25337	28865	31928
Denominator	103151	103524	104699	111879	119134
Data Source				See Field Level note	See Field Level Note
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	19	18	17	16

Notes - 2009
Source: CDC Pediatric Nutrition Surveillance System

Notes - 2008
Source: CDC Pediatric Nutrition Surveillance System

Notes - 2007
Source: CDC Pediatric Nutrition Surveillance System

a. Last Year's Accomplishments
The WIC program expanded access to healthy foods through the implementation of the new Food Packages. These new food packages, which went into effect October 1, 2009, provided access to fruits and vegetables and whole grains not previously offered by the WIC Program. The WIC program enhanced client knowledge and sought to help participants establish behavioral change goals as they relate to feeding practices and food choices using obesity prevention modules. Despite these efforts, preliminary Calendar Year 2009 data from the CDC's Pediatric Nutrition surveillance system indicated another increase in percent of children ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile. The percent reflected in the most recent CDC report showed 26.8% of the WIC children in this age group to have a BMI greater than or equal to the 85th percentile. In Calendar Year 2008 that percentage was 25.8%, a 3.9% rate of increase. National level data for CY 2009 is not available, but for 2008, the National rate of the same population stood at 31.3% overweight and obese. Participation of all children and infants has shown increases in the past two years: by 13,130 in 2008 and by 8,464 in 2009. With those increases, the WIC Program has experienced a decrease in the proportion of infants, 0-11 months, and steady increases in children between 12-23 months as well as 24-59 months. With the increases in participation rates, data also indicates shifts in the race/ethnic distribution of all children. The population of white children has steadily decreased over the past 4 years, while the distribution of black children has essentially stayed the same. The largest increase has been in Hispanic children as well as children of multiple races. Hispanic children reflected 20.6% of all children in 2009, up from 17.8% in 2005, while children of multiple races increased from 1.9% in 2005 to 2.8% in 2009. Rates of overweight increased across all race/ethnic groups with the exception of Asian/Pacific Islanders, who stayed the same. Rates of obesity increased in all groups except Whites, where the rate stayed at 11.3%.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Used WIC obesity prevention modules in counseling WIC participants.		X		
2. Targeted nutrition training to the educational needs of WIC participants.		X		
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

For this year, WIC staff activities have focused on learning and getting used to the vast changes to WIC foods and packages themselves, and then training participants. The average amount of time to conduct a WIC appointment has increased as a result of the additional explanations, participants appear to have embraced the changes. WIC staff continue to work with participants to deal with changes such as learning how to purchase fresh fruits and vegetables using the new Cash Value Voucher, reducing the fat content in the milk being purchased for their children two years and older, and exploring options such as soy beverage, tofu, canned beans and whole grain products. The Nutrition Education Committee developed flyers on the new food groups and staff continue to work with participants to make changes in their eating behaviors and feeding practices.

c. Plan for the Coming Year

Efforts for the coming year will include statewide implementation of a training that will assist staff in conducting participant-centered nutrition education that incorporates dialogue with participants to set small, achievable, realistic goals related to eating behaviors and feeding practices. The Guided Goal Setting Module was developed from the FFY2005 USDA Special Project Grant funding that was awarded to Pennsylvania WIC in September 2005. The module consists of ten units and a dvd of the training as developed and conducted by staff from Indiana University of Pennsylvania, the research partners in the project. This training is expected to assist staff in working with participants to facilitate behavior change, and is the first nutrition education methodology developed specifically for the WIC environment.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		14.2	14	14	13.4
Annual Indicator		13.7	13.8	13.6	
Numerator		19559	19786	19395	
Denominator		142397	143897	143099	
Data Source				See Field Level Note	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13.1	12.8	12.5	12.2	11.9

Notes - 2009

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics

Notes - 2007
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics

a. Last Year's Accomplishments
The annual performance objective for 2008 (14.0%) was met. In 2008, only 13.6% of live births were to women who smoked in the 3rd trimester. The annual performance objective has been met for the last three years. The Bureau of Health Promotion and Risk Reduction, Division of Tobacco Prevention and Control (DTPC) continued to partner with the Department of Public Welfare (DPW) to educate health-care providers to provide cessation services to Medicaid recipients, including training to educate low-income women about the dangers of smoking while pregnant and to encourage pregnant women who are receiving Medicaid benefits to quit smoking.

The DTPC also partnered with the Pennsylvania Area Health Education Center (PA AHEC) to ensure that healthcare providers had the knowledge and resources to identify and provide treatment recommendations and resources to every tobacco user seen in a healthcare setting. The PA AHEC developed education and training programs in tobacco cessation and intervention for practitioners and health professions students in the disciplines of physical and oral health based on the Agency for Healthcare Research and Quality (AHRQ) Smoking Cessation Clinical Practice Guidelines.

The PA AHEC assembled a statewide curriculum team of experts in the treatment and management of tobacco and tobacco addiction (representing the disciplines of medicine, dentistry, behavioral/mental health and allied health professions). The PA AHEC also provided Continuing Medical Education (CME) and Continuing Dental Education (CDE) accredited interdisciplinary training courses in tobacco cessation and intervention to physicians, dentists, Registered Nurses, nurse practitioners and physician assistants.

The DTPC secured a 12 month grant from the March of Dimes to:Increase the availability and quality of health care/prevention services for all women of childbearing age and/or pregnant women, and Reduce post partum return to tobacco use for women who quit during pregnancy.

March of Dimes grant funds were provided to the Allegheny County Regional Primary Contractor, Tobacco Free Allegheny (TFA). The target population was: low income, minority women receiving prenatal care at federally qualified health centers (FQHC) in Pittsburgh. The primary focus of the project was: pregnant women, and their families in an integrated circle of care during the pregnancy and the post-partum period. Finally, the secondary focus of the project was: Federally Qualified Health Center clinician education, training and daily standard of care are consistent with the current clinical practice guidelines and that each prenatal and post-partum visit includes an assessment of their tobacco use status, and a brief intervention that is motivational and educational.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contracted with county/municipal health departments via prenatal home visiting programs to provide education concerning	X	X	X	X

the risks of smoking while pregnant.				
2. Participated in the Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V) on the development of prevention strategies.				X
3. Bureau of Health Promotion and Risk Reduction continued its Free Quitline.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The March of Dimes Grant was continued and completed. The following outcomes were reported: 1) The authentic collaboration with the Allegheny County Maternal and Child Health programs and the Birth Circle Doulas provided reach into communities of need, using trusted practitioners. 2) The collateral material developed around the unifying theme, Quit for Love proved effective with a variety of audiences. 3) As a result of the training and support provided through this funding, the various programs of Maternal and Child Health in the county developed policies and procedures that embed tobacco screening, CO monitoring and brief interventions into their routine standard of care for all pregnant women and for all post-partum women or mothers of young children. 4) Likewise the Birth Circle doulas have made tobacco intervention an institutionalized part of the doula culture.

An overview of the March of Dimes initiative was provided to the eight regional primary contractors by TFA as a first step in replicating the initiative statewide.

The partnership with DPW has been continued. DTPC has provided presentations to the Healthy Beginnings contractors at DPW hosted conferences. In addition, DTPC continues to provide cessation training for healthcare professionals, targeting Medicaid providers.

c. Plan for the Coming Year

The AHEC initiative has ended due to funding reductions; however, DTPC continues to identify opportunities for health care providers to receive training and support on tobacco cessation control. Referrals are made to web based tobacco prevention and cessation training provided by the Pennsylvania Academy of Family Practice and the national American College of Obstetrics and Gynecology.

DTPC is required by state statute to release a Request For Proposal to identify eight regional primary contractors every three years. DTPC is in the process of identifying eight regional primary contractors who will begin service on October 1, 2010. Regional primary contractors have a generic work statement that has customized outcome measures for each region. All contractors are required to target cessation for pregnant and post-partum women.

DTPC will continue the partnership with DPW to increase utilization of cessation services. Efforts will be made to pilot a replication of the March of Dimes initiative in two regions.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	8.2	8.1	6	5.2	5.1
Annual Indicator	6.2	5.4	5.1	6.2	
Numerator	57	50	47	57	
Denominator	924662	928078	926505	922818	
Data Source				See Field Level Note	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.1	5	5	5	5

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

a. Last Year's Accomplishments
The 2008 performance objective for this measure was 5.2 suicide deaths per 100,000 teens age 15-19, the target was not met. There had been a steady decrease in the rate of suicide deaths in this age group in recent years. However, the rate of 6.2 in 2008 was an increase from the 2007 rate of 5.1. A variety of factors may have lead to the decrease in the rate of suicide deaths in this age group. Increased programming, increased attention to youth mental health issues, improved reporting of suicide as the cause of death, and the reporting of deaths from other causes may have been contributing factors to the increase in these rates.

Since the 1980's, Pennsylvania has made strong efforts toward the prevention of youth suicide through programs such as the Commonwealth Student Assistance Program (SAP), Services for Teens at Risk (STAR-Center), the Yellow Ribbon Program and a variety of other approaches in local areas.

On September 15-16, 2009, the Suicide Prevention Conference Advisory Committee, the Pennsylvania Youth Suicide Prevention Group, and the Pennsylvania Adult/Older Adult Suicide Prevention Advisory Group coordinated a Suicide Prevention Conference entitled, Creating Healthy Communities, in State College, PA. Approximately 200 people attended the conference which featured presentations addressing suicide prevention issues for youth, adults and older adults. Highlights of the conference included a panel of survivors of suicide sharing in a general session, a meeting focusing on the work of several county suicide prevention task forces, and a

session on "Pharmacological Management of Adolescent Depression in Primary Care."

Pennsylvania is in its second year of its three-year grant under the Garrett Lee Smith Memorial Act to implement an early identification system for youth at high risk for suicide (ages 14-24 years) within primary care medical settings of three Pennsylvania counties. This year's activities continued to focus on infrastructure and capacity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented a Grant to identify of high risk youth in primary care settings.			X	X
2. Coordinated a Suicide Prevention Conference that identified special populations at risk for suicide and identified which programs work best with certain diverse populations.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PA Youth Suicide Prevention Group continues to develop and fine-tune its five-year plan for PA regarding the prevention of youth suicide. The PA Department of Public Welfare, with support from the Departments of Health and Education, were awarded funds under the Garrett Lee Smith Memorial Act. The goal of this three-year grant is to implement an early identification system for youth at high risk for suicide (ages 14-24 years) within primary care medical settings of three Pennsylvania counties.

The Suicide Prevention Conference will not be held in 2010 due to limited resources. All youth, adult, and older adult advisory groups are moving forward to build and strengthen coalition infrastructure.

c. Plan for the Coming Year

The PA Department of Public Welfare, with support from the Departments of Health and Education, will continue with the implementation of the early identification system through stakeholder engagement and training to increase access to behavioral health services. Suicide Prevention Awareness Week activities will continue in September 2011.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	80.1	81.9	82.5	82.5	82.7
Annual Indicator	76.0	81.1	82.1	77.9	

Numerator	1727	1942	1963	1893	
Denominator	2272	2394	2390	2430	
Data Source				See Field Level Note	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82.7	82.9	82.9	82.9	82.9

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Source: PA Department of Health, Bureau of Health Statistics and research
2004 data have been revised as of April 26, 2007

a. Last Year's Accomplishments
The 2008 performance objective for this measure was 82.5 % and 77.9% was achieved, again missing the target. The data shows that the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased from 76.0 in 2005 to 82.1 in 2007. However, the percent decreased in 2008 to 77.9. Challenges persist that effect obstetrical care in the state. These challenges demonstrate a growing trend of diminished access to care for pregnant women and the need for a statewide solution to address the problem. Some factors at issue are a lack of timely access to prenatal care for certain populations, such as southeastern Pennsylvania's undocumented immigrant population, insufficient reimbursement for obstetrical services, including unfunded legislative mandates and inadequate provider networks. Obstetrician and Gynecological clinics are closing, due to financial constraints, especially in the rural and poor urban areas. Since 1997, 18 Maternity Units have closed their doors in southeastern Pennsylvania. With such a strong correlation between lack of prenatal care and low birth weight babies it is imperative that women, in all areas, have access to these vital services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in the Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V) to assist pregnant women and their families access social, physical and behavioral helath services.				X
2. Contracted with County/Municipal Health Deaprtment Education Programs to provide home based education to at risk women, address individual social and emotional needs, and provide pregnancy education.	X	X	X	X
3. Contracted with the County/Municipal Health Department Education programs to educate community providers about the	X	X	X	X

availability of the home visiting programs.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau is working with the ten county/municipal health departments to assist in providing increased access to prenatal care for low income pregnant women. The health departments offer clinics to obtain services, resource materials to locate a doctor and assistance in applying for public aid to encourage women to continue with prenatal care regularly throughout their pregnancy. Prenatal care services are provided to uninsurable women in areas of the state with high concentrations of undocumented women, specifically Montgomery and Philadelphia counties. In calendar year 2009, services were provided to 464 pregnant women who would otherwise be unserved. The Bureau is working with health departments in areas of the state impacted by the obstetrical shortage to explore viable alternatives to enhance access to care. Funding is being utilized to partner with county/municipal health departments to reopen an FQHC, which will provide maternity services to women in an otherwise underserved area.

Early prenatal care is proven to decrease the incidence of low birth weight infants. Low birth weight infants are more likely to experience long-term disability or to die during the first year of life than are infants of normal weight. While fiscal constraints preclude the Bureau from increasing funding for services, the county/municipal health departments are continually assessed to ensure positive outcomes from these programs.

c. Plan for the Coming Year

The county/municipal health departments will continue to work toward enhancing access to prenatal care for pregnant women. Funding will continue to be utilized to provide timely access to prenatal care for uninsurable women in Montgomery and Philadelphia counties. Programs such as Centering Pregnancy have had positive outcome measures in areas of normal birth weights, initiating breast feeding and natural births and will continue to be reviewed and assessed. Together the local, county and state public health workforces strive to find a statewide solution to the lack of timely access to prenatal care and improve the provider networks in Pennsylvania.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	83.5	84	81	79.6
Annual Indicator	81.1	80.1	79.6	79.4	
Numerator	97194	96697	95872	98657	
Denominator	119787	120770	120471	124291	
Data Source				See Field Level Note	
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	79.8	79.9	79.9	80	80

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

a. Last Year's Accomplishments
In 2008 the percent of women receiving prenatal care beginning in the first trimester was 79.4, missing the annual performance objective of 81.0%. There has been a slow decrease in this indicator, from a high of 81.1% in 2005 to 79.4% in 2008.

Through Block Grant funds, the Bureau continues to support various maternal and infant home visiting programs at the ten local/county/municipal health departments. The majority of these health departments have home visiting programs aimed at linking pregnant and parenting women with vital services. Through these programs, pregnant women lacking prenatal care are assisted in accessing care and are provided with education on a variety of topics throughout the prenatal period. Topics include education on healthy habits such as abstaining from drugs, alcohol and smoking during pregnancy, the importance of immunizations, and signs and symptoms of perinatal depression. The percent of non-smoking mother's during pregnancy has increased slightly from 2006 through 2008 with 82.4 and 83 percent respectively. Home visiting programs stress the importance of a healthy lifestyle during pregnancy and throughout life.

Additionally, the BFH was awarded $250,000 for a 2-year federal grant from the Maternal and Child Health Bureau for their First Time Motherhood/New Parents Initiative Grant. The purpose of the grant is to integrate the Life-Course Model into a social marketing campaign designed to increase public awareness among young low income women of childbearing age and their "influencers" of the importance of leading a healthy lifestyle to assure healthy pregnancies and prevent poor birth outcomes. Focus groups, street intercepts interviews and activity tracking systems constitute the methods used to conduct formative, process and outcome evaluation. In February 2009, a research contractor developed and field tested four questionnaires and Leader Guides to use with focus groups and street intercepts. Formative data were collected from six focus groups with 42 low income women ages 13-25, 123 street intercepts with Delaware County residents and one focus group with 13 medical care providers. The following topics were chosen based on the research results: nutrition; exercise; mental health; folic acid; sexual health; safe relationships and doctor visits. A marketing firm, Smells Like Green, Inc., was identified and the tagline "I DECIDE" for the campaign was developed. The theme and logo of "I DECIDE" were created to use on marketing materials like t-shirts, nail polish and back packs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V) assists pregnant women and their families access social, physical, and behaviral health services.				X
2. County/Municipal Helath Department Education Programs provide home based education to at risk women, address individual social and emotional needs, provide pregnancy educaiton, assess medical, financial and social situation to provide appropriate ref	X	X	X	X
3. Encourage early and regular care, make educational and informational materials available to perinatal women.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The BFH maintains grant agreements with the ten county/municipal health departments. The health departments have placed an increased focus on coordination with community resources to enhance the prenatal service programs available to low income families in their respective areas. They continue to provide home visiting services, education on the importance of prenatal care and health guidance to maintain a healthy pregnancy. Additionally, they have been provided with information on and encouraged to participate in the Text 4 Baby initiative. This initiative aims to provide new and expectant moms with important information geared toward improving maternal and infant health. Information provided through Text 4 Baby may serve as a bridge for expectant moms who have yet to enroll in prenatal care.

First Time Motherhood/New Parent Initiative promotional efforts include: a comprehensive website, marketing through social networking sites like Facebook, Twitter and MySpace; appearances at health fairs and special events; presentations at schools and public relations activities such as PSAs and news releases. Of those who responded to a website survey, 85% reported that the content made them want to explore the site more and that the information applied to their personal needs. Seventy-five percent agreed or strongly agreed that they would return to the website and nine out of ten agreed or strongly agreed that the site had user-friendly navigation and easy to read information.

c. Plan for the Coming Year

The First Time Motherhood grant is due to expire in August 31, 2010 and will not be extended/renewed. Lessons learned from the project will be used to sharpen, validate and integrate new perspectives and health promotion tools into existing county and local services that touch the lives of new mothers and fathers and women of reproductive age in general living in Delaware County. The county/municipal health departments continue to partner with Text 4 Baby to increase women's participation early and throughout their pregnancy along with local partnerships with social service agencies to ensure women are provided with the tools needed to maintain a healthy pregnancy. The Philadelphia Department of Public Health (PDPH) is currently working with Drexel University to develop a depression screening program which will provide a certificate and continuing education units for providers who complete the program. Providers have the ability to recognize and treat or refer for treatment women who may be experiencing depressive symptoms early on to improve the quality of their life and the lives of their families.

A strategic plan will be developed to implement the Life Course Model with all programs supported by Title V.

D. State Performance Measures

State Performance Measure 5: *Percent of callers who have expressed satisfaction with the services provided by the Special Kids Network Helpline.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		100	92	92	94.2
Annual Indicator	94.3	90.3	91.9	94.2	94.9
Numerator	482	167	406	311	223
Denominator	511	185	442	330	235
Data Source				See Field Level note	See Field Level Note
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94.6	95	95.2	95.5	

Notes - 2009
Source: Division of Community Systems Development and Outreach.
The MCH Block Grant satisfaction rate during calendar year 2009 is based on responses from families and professionals to the questions, "Would you call the Special Kids Network again?"

Notes - 2008
Source: Division of Community Systems Development and Outreach

The satisfaction rate during calendar year 2008 is based on responses from families and professionals to the question, “Would you call the Special Kids Network again?"

a. Last Year's Accomplishments
This State Performance Measure relates to National Performance Measure (NPM) 5, Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. Special Kids Network (SKN) is able to locate services whose existence may not be known to families and their providers. The SKN database contains almost 20,000 well-organized resources that are immediately available for referring callers to services. In addition to the resource management function within the Health and Human Services Call Center, the SKN System of Care contributes to the resource database through its Community Mapping initiative, expanding the number of referral resources. Both entities organize the resources using the L.A. Infoline Taxonomy of Human Services. When those mapped resources are used efficiently and appropriately, callers are prompted to encourage family members and acquaintances to use the helpline, and they will call again. While targeting an overall 94.2% satisfaction rate in 2009, 94% of families responding and 97% of professional providers responding to indicator survey questions expressed satisfaction for an overall satisfaction rate of 94.9%, exceeding the target.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Issued a survey to every permitting SKN caller to request evalution of helpline service and effectiveness of caller referrals to services.		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The SKN program is revisiting inclusion/exclusion criteria for the resource database. The HHSCC has a mechanism in place for tracking agencies surveyed and evaluating follow-ups whenever a survey is not returned. HHSCC was reluctant to deactivate an agency from the resource database whenever there was not a response from the agency. SKN made a decision to deactivate non-responsive agencies 2 years from the original survey date to assure the accuracy of information disseminated to its callers. Departments of Aging and Public Welfare and the Insurance Department agreed to utilize the revised inclusion/exclusion criteria for their helplines. HHSCC is in the process of targeting those agencies that cannot be verified for deactivation

c. Plan for the Coming Year

The HHSCC's new facebook page will expand the reach of call center programs to the public they serve, offering helpline information, a calendar of upcoming community events and a discussion page. This new social media feature will be monitored by HHSCC supervisory staff. Administrative permissions to update the site are in the planning stage.

State Performance Measure 6: *Rate of infant deaths as a result of Sudden Infant Death Syndrome (SIDS) and accidental suffocation and strangulation in bed per 1,000 live births.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		0.5	0.5	0.5	0.5
Annual Indicator	0.5	0.4	0.6	0.6	
Numerator	73	59	93	85	
Denominator	145033	148706	150322	148934	
Data Source				See Field Level Note	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0.5	0.5	0.5	0.5	

Notes - 2009

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Source: PA Department of Health, Bureau of Health Statistics and Research

a. Last Year's Accomplishments
The 2008 annual performance objective for this measure was 0.5 per 1,000 live births. In 2008, the rate was again 0.6, missing the target of 0.5. The rate has increased slightly since 2005 (0.5).

In 2009, legislation was introduced that would require the Department to establish a Sudden Infant Death Syndrome Education and Prevention Program to promote awareness and education related to SIDS and SUDI with an emphasis on the risk factors of SIDS and SUDI and safe sleeping practices for newborns and infants. This legislation would require that parents sign a commitment statement prior to discharge from the hospital or birth center acknowledging that they received and have an understanding of the educational materials provided regarding SIDS and SUDI. A public hearing was held on this bill in March 2009. The bill is still being reviewed by various committees.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted comprehensive multi-disciplinary reviews of child deaths throughout the Commonwealth.				X
2. Determined which deaths were preventable.				X
3. Developed prevention strategies to decrease child deaths.				X
4. Provided training and education on child death scene investigation to improve data and manner and cause of death.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Bureau of Family Health continues to provide SIDS education materials to hospitals and parent education programs across the Commonwealth to promote safe sleep environments. The Bureau of Family Health also continues to work with agencies such as the American Academy of Pediatrics, SIDS of PA and the Maternity Care Coalition to develop cost effective strategies to increase awareness and prevention efforts regarding SIDS.

c. Plan for the Coming Year
This will continue to be a state performance measure. The Bureau of Family Health is in the process of releasing a Request for Applications aimed at increasing prevention and awareness activities related to SIDS, SUDI and accidental suffocation and strangulation. Through this new initiative the Department will develop a Statewide SIDS program which is intended to promote safe sleep environments for infants as well as inform and educate the public and families about risk factors for SIDS and accidental suffocation and strangulation. The program will partner with an agency that is able to extend services to all 67 counties in Pennsylvania as well as utilize existing resources throughout Pennsylvania to increase knowledge about safe sleep practices.

The program will address health disparities as well as identify activities to address these disparities.

State Performance Measure 9: *The rate of pregnancy (per 1,000) among females ages 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective				22.3	23.9
Annual Indicator	22.3	23.6	23.9	24.4	
Numerator	6016	6370	6385	6397	
Denominator	269471	270122	267102	262295	
Data Source				See Field Level Note	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	23.6	23.5	23	23	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

a. Last Year's Accomplishments
The rate of pregnancy (per 1,000) among females 15 to 17 years of age has been increasing steadily since 2005 (22.3). In 2008, the rate reached 24.4 and the annual performance objective of 22.3 was not met demonstrating the need for comprehensive teen pregnancy prevention programming. The Division of Child and Adult Health Services partnered with the Department of Education, the Pennsylvania Coalition to Prevent Teen Pregnancy (PCPTP), the Allentown Health Bureau, and the Bethlehem Health Bureau to provide educators/school administrators in the Allentown/Bethlehem area with free training on science-based teen pregnancy prevention programs.

The Division of Child and Adult Health Services participated in stakeholder meetings and a Teen Pregnancy Prevention Forum that the PCPTP held to discuss how agencies/organizations throughout the Commonwealth can work together to promote and implement the use of science-based teen pregnancy prevention programs. The stakeholder group includes representatives from the Departments of Education and Public Welfare, Family Health Councils, Planned Parenthood, Advocates for Youth and the National Campaign.

The Division of Child and Adult Health Services continued to support the SAFETEENS website. SAFETEENS is an interactive educational website aimed at teens to provide them with information and links to community services and resources on wellness, self-esteem, and other character building themes. The Division also continued to support the four family health councils in the Commonwealth to provide reproductive health services, including contraception, to sexually

active teens under the age of 17.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Funded family planning clinical services, including routine gynecological care, contraceptives, and pregnancy testing for teens under the age of 17.	X			
2. Provided training to school administrators and educators on evidence-based approaches to teen pregnancy prevention in the Lehigh Valley.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Division has applied as the lead applicant to apply for the Teen Pregnancy Prevention: replication of Evidence-based Programs (Tier One) funding from the Office of Adolescent Health. For the application the Division created partnerships with the PCPTP, nine school districts, four municipal health departments, and one family health council. If awarded the evidence-based curriculum "Making Proud Choices" will be implemented in the nine school districts, four cities, and several counties in the Commonwealth, greatly increasing the number of evidence-based teen pregnancy prevention programs that are being implemented in Pennsylvania.

The Division hosted, as a follow up to the training on science-based approaches that was provided to educators in Allentown/Bethlehem in March 2010, a training on the "Sex-Ed 101" curriculum for health teachers and school nurses in the Allentown/Bethlehem area. The Division provided this training to thirty educators from seventeen school districts. This training was well received and many educators indicated they would be using the lessons in their classrooms.

The Division participates in the PCPTP stakeholder meetings to promote and implement the use of science-based teen pregnancy prevention programs. The Division also is continuing to provide Title V funding to the SAFETEENS website and the family health councils.

c. Plan for the Coming Year

The Division of Child and Adult Health Services will continue to provide support for the SAFETEENS website and the reproductive health services provided by the family health councils. The Division will actively pursue opportunities to promote the use of science-based teen pregnancy prevention programs. This includes applying for any available funding, continuing to partner with the PCPTP and other organizations who are promoting science-based teen pregnancy prevention programs, and provide technical assistance to local health departments and organizations on science-based programs.

State Performance Measure 10: *Percent of children ages 6 years and younger tested for elevated blood lead levels*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective				13	13.8
Annual Indicator		10.7	12.7	13.3	14.1
Numerator		109894	130954	137878	145996
Denominator		1031796	1030272	1035787	1034432
Data Source				See Field Level note	See Field Level Note
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13.8	14	15	16.5	

Notes - 2009
Numerator source: PA NEDSS
Denominator is an estimate not produced by the PA State Data Center

Notes - 2008
Numerator source: PA NEDSS
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA NEDSS
Denominator source: PA State Data Center

a. Last Year's Accomplishments
The Lead Program had implemented a variety of strategic initiatives to improve reporting to the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) and efforts to increase awareness through outreach and education in high-risk areas. These initiatives have resulted in an increase in children reported to have been tested for lead across the Commonwealth. Data for this performance measure for 2009 indicates that 14.1 percent of children ages 6 years of age and younger were tested for lead. This exceeded the annual performance objective of 13.8 percent. That represents a 6.0 percent increase in the percent of children ages 6 years of age and younger tested for lead in 2008 and a 11.0 percent increase from 2007. Childhood lead poisoning also remained in the news during 2008 and 2009, due to the continued findings of lead in a number of consumer products.

As a result of the Lead Program's continued focus the Data Match and Sharing Project with the Department of Public Welfare (DPW) was implemented, as DPW signed the Letter of Agreement July 24, 2009. The Lead Program released, disseminated, and posted its premier Surveillance Annual Report, which encompassed data from 2008, on the Department website. The Surveillance Annual Report offers a wealth of demographic information and data for children tested for lead in Pennsylvania, and will be released on an annual basis from this point forward. Case Managers continued to access, download, and print the Case Management Guidelines directly from PA-NEDSS. Childhood Lead Surveillance staff participated in discussion and planning for the Environmental Public Health Tracking Network (EPHTN) at the Department of Health. The PA Legacy (PAL) system ceased operations, thereby streamlining the process for importing lead reports into PA-NEDSS. Additional lead reporting laboratories began reporting through the streamlined, Pennsylvania Electronic Laboratory Reporting (PA-ELR) system. Pennsylvania reporting regulations remained in the review process. The Lead Program continued to seek support for the approval of proposed reporting regulation revisions that would tighten the reporting requirements and ultimately serve to improve the accuracy and timeliness of information received. PA Childhood Lead Poisoning Prevention Program (CLPPP) sub-grantees delivered sustained and comprehensive childhood lead poisoning prevention services in identified

high-risk areas of the Commonwealth.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Raised awareness of lead poisoning though outreach and educational programs for the community, parents, and health care practitioners.			X	X
2. Increased the flow of information to the public through networking with the Lead Elimination Partnership.				X
3. Tested children on-site and at off-site clinics, such as WIC clinics and health fairs.			X	
4. Used the Leadmobile to increase testing and outreach to harder-to-reach areas of the state.			X	
5. Continued participation on the statewide Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) team in an effort to propose improvements to this Web-based reporting and case management system for childhood lead investigators.		X		X
6. Continued to closely monitor reporting to PA-NEDSS to ensure full compliance across the laboratory reporting community.		X		X
7. Continued to improve analysis and reporting capabilities, including mapping tools in an effort to accurately identify potential service gaps and high risk populations.		X		
8.				
9.				
10.				

b. Current Activities

With the Data Match and Sharing Agreement with DPW in place, staff receive data regarding Pennsylvania's Medical Assistance children who have been tested for lead, and exchange corresponding information with DPW on a quarterly basis. Updates and enhancements to the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) continue in an effort to improve and refine this Web-based case management system for childhood lead investigators statewide. Ongoing monitoring and oversight of laboratories reporting childhood lead results to PA-NEDSS continues as they are brought on-board to the streamlined Pennsylvania Electronic Laboratory Reporting (PA-ELR) pipeline. As a result of these efforts, data quality, reporting timeliness and consistency have improved. Staff continue to participate in the planning and development of the Department's Environmental Public Health Tracking Network (EPHTN) project. In addition to other environmentally-related datasets and information, the EPHTN will provide and present publicly childhood lead data reflecting those Pennsylvania children tested for lead before their third birthday. Ten PA CLPPP sub-grantees continue to provide comprehensive services in targeted high-risk areas, and staff monitors those CLPPPs' use of PA-NEDSS on an ongoing basis. Staff also work closely with the Healthy Homes Foster Care Program, which uses a holistic approach in considering housing as a health indicator and source of disease.

c. Plan for the Coming Year

The Ten PA CLPPP sub-grantees will continue to increase the amount of lead testing through efforts to enhance and expand outreach. This will include presentations to families and interested organizations, collaboration with community groups, attendance at health fairs, on-site and off-site clinics, participation in National Lead Week, and use of a mobile lead-testing unit to reach

hard-to-access areas.

Discussions will also continue with legal staff and DPW regarding reimbursement for case management services provided by CLPPPs. This reimbursement could provide another funding stream and thereby augment current program activities.

Efforts to continue strengthening and improving surveillance capabilities are expected. The close monitoring of Childhood Lead reporting will continue in an effort to further improve reporting timeliness, data quality, accuracy and completeness. Childhood Lead Surveillance Program staff will undergo advanced ACCESS training and develop a database for use with Quarterly Reports provided by the CLPPPs. This will improve the quality of the data and the efficiency with which it is gathered, as well as monitoring efforts. Staff will also take training for the use of geo-coded address data and mapping software (ArcGIS 9.3), with the goal of incorporating this software into ongoing analysis and reporting projects. Through these efforts, a deeper and closer analysis of Pennsylvania's high risk areas and populations is expected. Also planned is further analysis of the data from the DPW Data Match and Sharing Project, resulting in a baseline number and percentage of lead-tested children receiving Medical Assistance. In addition, the theoretical and practical framework of the Life Course Model will be reviewed to determine how to incorporate strategies to address the social determinants of health related to housing.

State Performance Measure 11: *The percent of tested children ages 6 years and younger with confirmed elevated blood lead levels.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective				2.3	2.3
Annual Indicator			2.3	2.2	1.9
Numerator			3026	2996	2750
Denominator			130954	137878	145996
Data Source				See Field Level note	See Field Level Note
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.2	2.2	2.1	2	

Notes - 2009
Source: PA NEDSS
The annual performance objective is not being changed because there is no direct correlation between the number of children tested and the percentage of confirmed elevated results, making the confirmed elevated percentage difficult to predict. Although the CLPPPs are currently testing in identified high-risk areas, only 30% of those children are being tested. It is possible that as those untested populations are tested, the number of confirmed elevated results as a percentage of the population could increase.

Notes - 2008
Source: PA NEDSS

Notes - 2007
Source: PA NEDSS

a. Last Year's Accomplishments

Data for this performance measure for 2009 indicates that 1.9 percent of children ages 6 years of age and younger who were tested for lead had confirmed elevated blood lead levels. That represents a 13.6 percent decrease in the percent of children ages 6 years of age and younger tested with confirmed elevated blood lead levels in 2008 (2.2 percent). As laboratory reporting to PA-NEDSS improved, the percentage of children with confirmed elevated lead levels has decreased and the data has become more accurate. Through monitoring, outreach and coordinated efforts to bring laboratories more closely in line with reporting requirements, the number of incoming low lead level results has increased. As a result, the percentage of confirmed elevated children has dropped as the data has become more reflective of the population.

In addition to improved and more comprehensive reporting from laboratories, Pennsylvania's geometric mean blood lead level has been dropping. This reflects a national trend toward lower lead levels. It is also likely a reflection in part, to outreach, education, and case management conducted by Pennsylvania's CLPPPs

The Lead Program's initiative to expand reporting has resulted in additional lead reporting laboratories to begin transmitting data through the streamlined, Pennsylvania Electronic Laboratory Reporting (PA-ELR) system. That resulted in more timely and accurate reporting which, in turn, has lead to more accurate data on statewide lead testing and follow-up activities. Discussion and planning began on possible Childhood Lead Surveillance participation in the Environmental Public Health Tracking Network (EPHTN) at the Department of Health. The ten PA CLPPP sub-grantees continued to provide comprehensive childhood lead poisoning prevention services in identified high-risk areas of the Commonwealth. As a result of the Lead Program's continued focus, the data match and sharing project with The Department of Public Welfare (DPW) was implemented, as DPW signed the Letter of Agreement July 24, 2009. Support continues to be sought for the proposed reporting regulations that are undergoing the review process, and if approved, will tighten the reporting requirements and ultimately serve to improve the accuracy and timeliness of information received.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Raised awareness of lead poisoning though outreach and educational programs for the community, parents, and health care practitioners.			X	X
2. Increased the flow of information to the public through networking with the Lead Elimination Partnership.				X
3. Tested children on-site and at off-site clinics, such as WIC clinics and health fairs.		X	X	
4. Used the Leadmobile to increase testing and outreach to harder-to-reach areas of the state.		X	X	
5. Performed case management services to make parents, families, and communities more aware of the importance of confirmatory tests, and how to prevent lead poisoning.	X		X	
6. Continued participation on the statewide Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) team in an effort to propose improvements to this Web-based reporting and case management system for childhood lead investigators.		X		X
7. Continued to closely monitor reporting to PA-NEDSS to ensure full compliance across the laboratory reporting community.		X		X

8. Continued to improve analysis and reporting capabilities, including mapping tools in an effort to accurately identify potential service gaps and high risk populations.		X		
9.				
10.				

b. Current Activities

CLPPP used data from the Department's Bureau of Health Statistics and the U.S. Census Bureau to identify areas of the state at the highest risk for lead poisoning based on the population of children under six years old, poverty status and age of housing. Ten sub-grantees provide comprehensive services in the targeted high-risk areas. A Data Match and Sharing Agreement with DPW enables staff to receive data about PA's Medical Assistance children who have been tested for lead; corresponding information is exchanged with DPW quarterly. Updates and enhancements to the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) continue in an effort to improve this Web-based case management system for lead investigators. Monitoring and oversight of laboratories reporting childhood lead results to PA-NEDSS continues as they are brought on-board to the streamlined PA Electronic Laboratory Reporting pipeline. Data quality, reporting timeliness and consistency have improved as a result of these efforts. Staff continue to participate in the planning and development of the Department's Environmental Public Health Tracking Network (EPHTN). EPHTN will provide and present publicly data on PA children tested for lead before their 3rd birthday, as well as other environmentally-related datasets. Staff also work closely with the Healthy Homes Foster Care Program, which uses a holistic approach in considering housing as a health indicator and source of disease.

c. Plan for the Coming Year

The Ten PA CLPPP sub-grantees will continue to perform, enhance, and expand outreach in an effort to increase the awareness of childhood lead poisoning. This will include presentations to families, interested organizations, and physicians; collaboration with community groups, attendance at health fairs, on-site and off-site clinics, participation in National Lead Week, and use of a mobile lead-testing unit to reach hard-to-access areas. By making families more aware of lead poisoning in children, it is anticipated that more families will take their children to get tested.

Discussions will also continue with legal staff and DPW regarding reimbursement for case management services provided by CLPPPs. This reimbursement could provide another funding stream and thereby augment current program activities.

Efforts to continue strengthening and improving surveillance capabilities are expected. The close monitoring of Childhood Lead reporting will continue in an effort to further improve reporting timeliness, data quality, accuracy and completeness. The Childhood Lead Surveillance Program staff will undergo advanced ACCESS training and develop a database for use with Quarterly Reports provided by the CLPPPs. This will improve the quality of the data and the efficiency with which it is gathered, which in turn will further improve monitoring efforts. In addition to outreach and more timely reporting from the CLPPPs, streamlined reporting from the laboratories through ELR will result in more reports being entered into PA-NEDSS. With more tests in PA-NEDSS, the data will be more representative of the population and consequently more accurate, improving the quality of data analysis and the ability to evaluate program effectiveness. In addition, staff will undergo training for the use of geo-coded address data and mapping software (ArcGIS 9.3), with the goal of incorporating this software into ongoing analysis and reporting projects. Through these efforts, a deeper and closer analysis of Pennsylvania's high risk areas and populations is expected. Also planned is further analysis of the data from the DPW data match and sharing project, resulting in a baseline number and percentage of children receiving Medical Assistance who have been tested for lead.

State Performance Measure 12: *The percentage of statewide breastfeeding initiation*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective				67	68
Annual Indicator	63.7	64.6	65.4	66.5	
Numerator	86720	90282	92712	94789	
Denominator	136168	139794	141705	142543	
Data Source				See Field Level Note	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	69	70	71	72	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Source: PA Department of Health, Bureau of Health Statistics and Research

a. Last Year's Accomplishments
In 2008 the data for this state performance measure showed that 66.5% of women who gave birth to a live baby initiated breastfeeding. This shows a slow but steady increase from 63.7% in 2005 to the present. This percentage depicts the total initiation rates; however, there continues to be clear racial disparities as only 54.9% of Black women initiated breastfeeding vs. 81.9% of Asian/PI women, 67.6% of Hispanic women and 68.1% of White women. Several methods have been utilized depending on the target audience whether it be the pregnant teen, first time mother, grandmother, and/or provider. The Bureau has developed new print materials and ensured that all have been translated immediately into the Spanish language. All of the print materials have been posted on the website; the site has been updated for easier access.

Breastfeeding activities within the WIC Program continued to focus on increasing initiation rates and decreasing supplemental formula issuance. All newly hired staff were trained on the WIC Program's breastfeeding counseling protocol and improving the breastfeeding curriculum. The training programs are an ongoing statewide objective designed to address common cultural barriers that deter women from initiating breastfeeding.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinated the Happiest Baby Initiative in Pennsylvania to promote breastfeeding duration			X	X
2. Participated in the EPIC Best Project to teach physicians and their office staff the benefits of breastfeeding				X
3. Evaluation of data based on a geographic focus to assess				X

where activities/intervention is necessary				
4. Conducted WIC training to include emphasis on the new regulations and the new food package				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Due to the changes with USDA legislation, the largest share of activities have been directed toward preparing staff and participants for the vast changes with the breastfeeding food packages. Public education materials, policies and eight self-study modules were developed to train staff on using the new food packages as a way to promote exclusive breastfeeding as well as limit the use of supplemental formula and increase the number of women eligible for the partial breastfeeding package.

The breastfeeding initiation rates by county and by hospital have been posted on the Department website. This information has been successfully used at the local level to advocate for change, especially in those counties and hospitals with low initiation rates.

The Breastfeeding Coordinator was an active contributor in two obesity reduction initiatives sponsored by the Bureau of Chronic Disease using the Prevention Block Grant funds to conduct training sessions about the benefits of breastfeeding in physician's offices and to create the Childhood obesity Prevention Plan.

c. Plan for the Coming Year
The BFH will develop a breastfeeding strategic plan. In the development of the strategic plan, data analysis will be completed to determine what geographic areas and specific populations have lower rates of breastfeeding initiation.

State Performance Measure 13: *The percentage of infants with failed hearing screenings that are lost to follow-up*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective				19.5	15.9
Annual Indicator	19.3	20.7	15.9	6.7	
Numerator	271	290	220	127	
Denominator	1402	1400	1383	1887	
Data Source				See Field Level Note	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.7	15.5	15.3	15.1	

Notes - 2009
Data not available because of a 1 year turn-around time in final data. The annual performance objective for this measure has been updated to bring objectives in line with improved lost to follow-up rates. The 2008 data on this performance measure indicates that 6.73 percent of infants who failed hearing screenings were lost to follow-up.

Notes - 2008
Source: Division of Newborn Screening and Genetics.

Notes - 2007
Source: Division of Newborn Screening and Genetics

a. Last Year's Accomplishments
The Newborn Hearing Screening Program continued to evaluate the issue of lost to follow-up which is a nationwide phenomenon in the field of newborn hearing screening. In 2009 the Newborn Hearing Screening Program updated the individual reporting form that hospitals use to refer a child for follow-up tracking. A second contact was added to the form as well as clear instructions on how to complete the form. This may impact the ability for staff to locate the families. These new forms were distributed along with the new instructions to all hospitals with birthing units and the midwives that participate in the newborn hearing screening out of hospital birth program.

Enclosures in all of the letters the follow-up staffs send out to families and primary care providers were updated. Included in the parent letters are the parent checklist, a newborn screening brochure and a milestone brochure with key information on signs to look for during language development. In the physician mailing included are, a letter with the child's screening results, a parent checklist and a rack card on physician training opportunity via our On-line EHDI web-training format. The web training allow physicians to receive education and free continuing education credits.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Diagnositc Evaluation: provided technical support to pediatric audiologists to administer diagnostic exams.	X			
2. Screening: provided technical support to hospitals to administer pass/fail hearing screenings.	X		X	
3. Follow up: contacted families and PCP for further appointment and diagnostic information.	X			
4. Intervention: referred to early intervention services, hearing aids, sign language.	X			
5. Education and training: provided PCP education on newborn hearing screening diagnositc protocols and early intervention coordinator education.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Program has determined that the largest numbers of loss to follow-up cases are those infants that were not referred to the Department for follow-up. Implementation of a new data system is planned for 2010. Electronic reporting capabilities will improve referrals to the Department. Once complete and functioning, an evaluation of the data will provide insight into issues that impact lost to follow-up such as cost for a diagnostic evaluation, parent's refusal to continue in the process, and certain geographic areas where families are lost. Improving communications between

medical providers will also decrease loss to follow-up cases. To improve communications a PCP/Family Care Plan was developed, which will be a conduit for multiple providers to share information. The goal is to develop a plan that the family will take with them to their appointments so the providers and family can track the child's progress. Three parent stakeholders meetings were held on family support. During these sessions, parents spoke of concerns during the screening process and difficulties finding a qualified audiologist that could test a young child. To increase capacity the Program will host an in-depth Pediatric Audiologist training, conducted by the National Center for Hearing Assessment and Management. The Training includes online discussion and readings as well as four days of on-site hands on trainings. Funding for this training will be provided through a HRSA Supplement grant.

c. Plan for the Coming Year

The enhanced hospital technical assistance project is being planned and is hoped to improve the number of children that are referred to the Bureau for follow-up. Over time it has become clear that the majority of lost to follow-up cases are referrals for failed screenings that are never sent to the department for follow-up. Through data analysis it was found that the number of children not passing the screening on the monthly hospital aggregate reports do not equal the number of corresponding referrals. The goal is to uncover the issues regarding the required reporting and screening practices so screening rates and referrals can improve. If the number of referrals increases then the number of lost to follow-up cases should decrease. Additionally, electronic reporting with the OZ system and hospitals with compatible hearing screening units will streamline the data gathering process for the program. The audiologist training planned for 2011will increase community capacity to provide diagnostic care to children under the age of three, and decrease the loss to follow-up rates.

E. Health Status Indicators

Introduction

The following indicators document the health of the maternal and child population in the Commonwealth.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.3	8.5	8.4	8.3	
Numerator	12045	12479	12496	12301	
Denominator	144278	147333	148683	148448	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008

Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research
2004 data have been revised as of April 26, 2007

Narrative:
While the percentage of live births resulting in a low birth weight infant in 2008 (8.3) was not significantly different from that observed in 2007 (8.4), the 2008 percentage shows a slight decline for the second year in a row. This compares to the most recent national statistics (2007) showing that the percent of low birth weight infants was 8.2. Some possible risk factors for mothers that contribute to delivering low birth weight infants include: poverty, lack of education, decreased age a delivery, and lack of prenatal care. Programs that target interventions designed to decrease or eliminate these risk factors continue to need to be developed. The Bureau, through its community programs, continues to emphasize the importance of early and adequate prenatal care in an effort to combat the incidence of low birth weight and very low birth weight babies. Additionally, Bureau staff are analyzing available PRAMS date to assist in understanding factors underlying these trends.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.6	6.6	6.6	6.5	
Numerator	9139	9411	9452	9238	
Denominator	139143	142021	143431	143096	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research
2004 data have been revised as of April 26, 2007

Narrative:

The percentage of live singleton births resulting in a low birth weight infant remained steady at 6.6% from 2005 to 2007. However, there was a very slight decline to 6.5% in 2008. The Bureau, through its community programs, continues to emphasize the importance of early and adequate prenatal care in an effort to combat the incidence of low birth weight and very low birth weight babies. Additionally, Bureau staff are analyzing available PRAMS date to assist in understanding factors underlying these trends.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.6	1.6	1.6	
Numerator	2272	2394	2390	2430	
Denominator	144278	147333	148683	148448	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research
2004 data have been revised as of April 26, 2007

Narrative:
The percentage of live births resulting in a very low birth weight infant has remained constant at 1.6 percent over the last four years (2005-2008). The most recent national statistics for very low birth weight infants from 2007 was 1.5 percent. This is a very low percent, but risk factors and interventions listed for Health status Indicator 01A also apply to this indicator. The Bureau, through its community programs, continues to emphasize the importance of early and adequate prenatal care in an effort to combat the incidence of low birth weight and very low birth weight babies. Additionally, Bureau staff are analyzing available PRAMS date to assist in understanding factors underlying these trends.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.3	1.2	1.2	
Numerator	1690	1808	1768	1776	

Denominator	139143	142021	143431	143096	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research

Notes - 2007
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research
2004 data have been revised as of April 26, 2007

Narrative:
For three of the last four years the percentage of live singleton births resulting in a very low birth weight infant was 1.2% (2004, 2007 and 2008). In 2006, it was 1.3%. This is also a very low percent, but risk factors and interventions listed for Health Status Indicator 01A also apply to this indicator.
The Bureau, through its community programs, continues to emphasize the importance of early and adequate prenatal care in an effort to combat the incidence of low birth weight and very low birth weight babies. Additionally, Bureau staff are analyzing available PRAMS date to assist in understanding factors underlying these trends.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.3	6.1	7.4	5.8	
Numerator	146	140	169	133	
Denominator	2326570	2313503	2299158	2290858	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Narrative:
The 2008 death rate due to unintentional injuries among children 14 years of age and younger was 5.8 per 100,000. This death rate is a decline from 2007 (7.4) and is the lowest rate over the last four years. The Safe Kids PA Coalition and its network of local affiliated chapters and coalitions continue to develop and implement statewide and local prevention programs to address the leading causes of childhood fatal injuries (motor vehicles, poisonings, drowning, and bicycle/pedestrian issues). This network is rich with passionate volunteers that have developed expertise to help communities address childhood injury issues. To further enhance this network, the Department is increasing the available funding for development, implementation, and evaluation of local injury prevention programs that will reduce the burden of injury among youth.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.3	2.9	2.2	1.4	
Numerator	54	66	50	32	
Denominator	2326570	2313503	2299158	2290858	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Narrative:
Among children 14 years of age and younger, the death rate for unintentional injuries due to motor vehicle crashes was 1.4 per 100,000. This death rate is the lowest in the last four years. One of the major reasons for a decrease in the unintentional injury rate due to motor vehicle

crashes in this age group could be the increase in the use of car seats and seat belts. The Safe Kids PA Coalition and its network of local affiliated chapters and coalitions continue to develop and implement statewide and local prevention programs to address motor vehicle crashes as the leading cause of childhood deaths. This network partners with local organizations that receive federal highway funding in order to complement efforts to promote child passenger safety. To further enhance this network, the Department is increasing the available funding for development, implementation, and evaluation of local injury prevention programs that will promote child passenger safety.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.2	20.1	22.4	20.3	
Numerator	429	362	405	367	
Denominator	1776217	1800534	1808240	1809067	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Bureau of Health Statistics and Research
Denominator source: PA State Data Center

Narrative:
The death rate from unintentional injuries associated with motor vehicle accidents in 2008 among adolescents 15 to 24 years of age was 20.3 per 100,000, a decrease from 22.4 in 2007. Pennsylvania is fortunate to have a Graduated Driver Licensing system that is fair compared to national standards yet there is room for improvement to limit the number of passengers being driven by a teen driver as well as requirements for seat belt use and bans on wireless devices. Through the Department's Injury Community Planning Group, the Department of Transportation, Children's Hospital of Philadelphia, and the PA Child Death Review State Team, efforts are under way to develop a Teen Driving Safety Alliance. The purpose of the Alliance is to bring together stakeholders from local communities and statewide organizations to coordinate outreach and policy efforts that will produce a safe driving environment for all road users.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	258.9	260.9	246.9	228.7	
Numerator	6024	6036	5677	5239	
Denominator	2326570	2313503	2299158	2290858	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 11 to 12 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Division of Health Risk Reduction
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Division of Health Risk Reduction
Denominator source: PA State Data Center

Narrative:
The rate of all nonfatal injuries among children aged 14 years and younger has dropped from 258.9 in 2005 to 228.7 in 2008. This rate is the lowest in the last four years. The Safe Kids PA Coalition and its network of local affiliated chapters and coalitions continue to develop and implement statewide and local prevention programs to address the leading causes of childhood injury hospitalizations (motor vehicles, falls, poisonings, near drownings, and bicycle/pedestrian issues). These programs appear to have raised awareness in such things as the importance of using car seats and seat belts. Also there has been an increase in programs that give away bicycle helmets to children as well as providing them with bicycle safety training. An increase in programs emphasizing water safety can contribute to a decrease in near drowning episodes. Programs such as play ground safety, can also be a reason for a decrease in the number of falls experienced by children at this age. Finally there has been an increase in programs targeting poison safety in this age group. This network is rich with passionate volunteers that have developed expertise to help communities address childhood injury issues. To further enhance this network, the Department is increasing the available funding for development, implementation, and evaluation of local injury prevention programs that will reduce the burden of injury among youth.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	38.9	36.2	32.8	27.0	
Numerator	906	838	753	619	
Denominator	2326570	2313503	2299158	2290858	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 11 to 12 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Division of Health Risk Reduction
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Division of Health Risk Reduction
Denominator source: PA State Data Center

Narrative:
In 2008, the rate of all nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger was 27.0. This shows a steady decrease from 38.9 in 2005 to the present. The Safe Kids PA Coalition and its network of local affiliated chapters and coalitions continue to develop and implement statewide and local prevention programs to address motor vehicle crashes as one of the leading causes of childhood injuries. These programs emphasize the importance of car seats for the very young children and seatbelts of the older children. These base interventions go a long way in decreasing the nonfatal injury rates due to motor vehicle crashes in this age group. This network partners with local organizations that receive federal highway funding in order to complement efforts to promote child passenger safety. To further enhance this network, the Department is increasing the available funding for development, implementation, and evaluation of local injury prevention programs that will promote child passenger safety.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	197.4	199.1	183.5	156.4	
Numerator	3506	3585	3318	2829	
Denominator	1776217	1800534	1808240	1809067	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 11 to 12 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Division of Health Risk Reduction
Denominator source: PA State Data Center

Notes - 2007
Numerator source: PA Department of Health, Division of Health Risk Reduction
Denominator source: PA State Data Center

Narrative:
The rate of all nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years has decreased from 197.4 in 2005 to 156.4 in 2008. The 2008 rate is the lowest rate in the last four years. Pennsylvania is fortunate to have a Graduated Driver Licensing system that is fair compared to national standards yet there is room for improvement to limit the number of passengers being driven by a teen driver as well as requirements for seat belt use and bans on wireless devices. Through the Department's Injury Community Planning Group, the Department of Transportation, Children's Hospital of Philadelphia, and the PA Child Death Review State Team, efforts are under way to develop a Teen Driving Safety Alliance. The purpose of the Alliance is to bring together stakeholders from local communities and statewide organizations to coordinate outreach and policy efforts that will produce a safe driving environment for all road users.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	25.2	26.1	27.9	28.2	
Numerator	11517	12033	12816	12912	
Denominator	457118	460542	459738	458373	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 11 to 12 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Division of Communicable Diseases, reported to them in accordance with PA's Communicable Disease Act
Denominator source: PA State Data Center

Notes - 2007
Numerator Source: PA Department of Health, Division of Communicable Diseases, reported to them in accordance with PA's Communicable Disease Act.
Denominator Source: PA State Data Center

Narrative:
The rate of reported cases of Chlamydia among women aged 15 to 19 has steadily increased, from 25.2 in 2005 to 28.2 in 2008. The availability of urine based amplified chlamydia testing has improved screening rates, especially among males who traditionally had to have a urethral swab utilized for testing. Clinics and physicians in the private and public sectors are more inclined to offer chlamydia testing to males and females (who are not having a tabled examination) because of ease of use. Many times, partners of infected patients in the past were presumptively treated without testing, with urine testing partners are tested as well before presumptive treatment. The STD Program at the PA Department of Health has been promoting annual screening for women at the time of annual exam and whenever getting urine pregnancy test in contracted clinics throughout PA. The STD Program has additionally reached out with campaigns to increase chlamydia screening in the private sector for young women 25 and underwith outreach to members of the PA Chapter of the American Academy of Pediatrics and the PA Chapter of American College of Obstetricians and Gynecologists. With more screening, there will be an increase in reported cases of infection.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.1	7.6	8.3	8.3	
Numerator	14582	15513	16751	16666	
Denominator	2044703	2039437	2020889	2009713	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data not available. Usually these data are available 11 to 12 months from the close of the calendar year.

Notes - 2008
Numerator source: PA Department of Health, Division of Communicable Diseases, reported to them in accordance with PA's Communicable Disease Act
Denominator source: PA State Data Center

Notes - 2007
Numerator Source: PA Department of Health, Division of Communicable Diseases, reported to them in accordance with PA's Communicable Disease Act.
Denominator source: PA State Data Center

Narrative:
In 2008, the rate per 1,000 women aged 20 to 44 with a reported case of Chlamydia was 8.3 which is an increase from the 2005 rate of 7.1. See Health Status Indicator 5A for further information.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	150344	122635	21161	0	5002	0	0	1546
Children 1 through 4	586858	473031	81068	0	18535	0	0	14224
Children 5 through 9	755144	613466	101231	0	19958	0	0	20489
Children 10 through 14	798512	652381	108796	0	18119	0	0	19216
Children 15 through 19	922818	761172	122074	0	21744	0	0	17828
Children 20 through 24	886249	727670	120276	0	23460	0	0	14843
Children 0 through 24	4099925	3350355	554606	0	106818	0	0	88146

Notes - 2011
American Indian or Native Alaskan: Na
Native Hawaiian or other Pacific Islander included in Asian.
More than one race reported: Na

American Indian or Native Alaskan: Na
Native Hawaiian or other Pacific Islander included in Asian.
More than one race reported: Na

American Indian or Native Alaskan: Na
Native Hawaiian or other Pacific Islander included in Asian.
More than one race reported: Na

American Indian or Native Alaskan: Na
Native Hawaiian or other Pacific Islander included in Asian.
More than one race reported: Na

American Indian or Native Alaskan: Na
Native Hawaiian or other Pacific Islander included in Asian.
More than one race reported: Na

American Indian or Native Alaskan: Na
Native Hawaiian or other Pacific Islander included in Asian.
More than one race reported: Na

Narrative:
Based on estimates from the Pennsylvania State Data Center, there were 4,099,925 infants and adolescents 0 to 24 years of age residing in Pennsylvania in 2008. Infants less than 1 year of age (3.7%) comprised the smallest percentage of this population, followed by children 1 to 4 years of age (14.3%) and children 5 to 9 years of age (18.4%). Adolescents 10 to 14 years of age accounted for 19.5 percent of the population under 25 years of age, while those 15 to 19 years of

age and those 20 to 24 years of age accounted for 22.5% and 21.6%, respectively. Almost 82% of this population was White, 13.5% was Black, and 2.6% was Asian/Pacific Islander.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	136182	14162	0
Children 1 through 4	533036	53822	0
Children 5 through 9	694800	60344	0
Children 10 through 14	742512	56000	0
Children 15 through 19	863817	59001	0
Children 20 through 24	833503	52746	0
Children 0 through 24	3803850	296075	0

Notes - 2011

Narrative:
The age distributions within the Hispanic (which can be of any race) population deviated slightly from that seen within the state as a whole. Approximately 23% of the Hispanic population under 25 years of age was accounted for by infants and children 4 years of age and younger, while a smaller percentage was accounted for by those 20 to 24 years of age (17.8%).

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	158	38	87	0	0	0	0	33
Women 15 through 17	4269	1830	1518	12	34	6	0	869
Women 18 through 19	9439	5167	2764	24	59	10	0	1415
Women 20 through 34	112353	82485	15839	163	4057	59	0	9750
Women 35 or older	22632	18051	2212	19	1164	9	0	1177
Women of all ages	148851	107571	22420	218	5314	84	0	13244

Notes - 2011
More than one race reported: Na

More than one race reported: Na

More than one race reported: Na

More than one race reported: Na

More than one race reported: Na

Narrative:
In 2008, there were 148,851 resident live births reported (excluding women of unknown age giving birth). The majority of these live births in 2008 occurred among White women (72.3%), followed by Black women (15.1%), Asian/Pacific Islander women (3.6%), and American Indian/Native Alaskan women (0.1%).
Approximately 9 percent of these live births in 2008 were to adolescents less than 20 years of age. Over 75% of these resident live births occurred among women 20 to 34 years of age, and 15.2% among women 35 years of age and older.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	119	35	4
Women 15 through 17	3226	939	104
Women 18 through 19	7733	1533	173
Women 20 through 34	100895	10129	1329
Women 35 or older	21089	1243	300
Women of all ages	133062	13879	1910

Notes - 2011

Narrative:
Hispanic (which can be of any race) women accounted for 9.3% of these resident live births. Eighteen percent of the live births in 2008 to Hispanic women were to adolescents less than 20 years of age, 73% to Hispanic women 20 to 34 years of age, and only 9% to Hispanic women 35 years of age and older.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1090	716	322	1	24	0	0	27
Children 1	163	116	41	0	3	0	0	3

through 4								
Children 5 through 9	77	47	27	0	2	0	0	1
Children 10 through 14	108	79	26	1	1	0	0	1
Children 15 through 19	484	357	122	0	4	0	0	1
Children 20 through 24	842	632	195	2	11	0	0	2
Children 0 through 24	2764	1947	733	4	45	0	0	35

Notes - 2011
Native Hawaiian or other Pacific Islander included in Asian. More than one race reported: Na

Native Hawaiian or other Pacific Islander included in Asian. More than one race reported: Na

Native Hawaiian or other Pacific Islander included in Asian. More than one race reported: Na

Native Hawaiian or other Pacific Islander included in Asian. More than one race reported: Na

Native Hawaiian or other Pacific Islander included in Asian. More than one race reported: Na

Native Hawaiian or other Pacific Islander included in Asian. More than one race reported: Na

Narrative:
In 2008 there were 2,764 deaths among infants and children aged 0 through 24 years. Over 39% of these deaths were among infants, followed by 30.5% among youth aged 20 through 24 and 17.5% among youth aged 15 through 19. Children aged 1 through 4 accounted for 5.9% and children aged 10 through 14 accounted for 3.9% of these deaths. Only 2.8% of these deaths were among children aged 5 through 9. Whites accounted for over 70% of these deaths, Blacks for 26.5%, and Asian/Pacific Islanders for only 1.6%.

The three largest categories of manner of death in Pennsylvania child fatalities are natural, accidental, and homicide. Together they account for 91% of child fatalities. The top three preventable deaths for children ages one to fourteen are motor vehicle accidents, fire and burns and drowning. Approximately half of home fire deaths occur in homes without smoke alarms. Some experts estimate that there could be a 50% to 70% decrease in fire deaths with working smoke alarms in the home. Initiatives for education and reduction in fire deaths consist of smoke alarm distribution programs, legislation to require smoke alarms to be installed in new and existing homes and child education on how to escape from a fire.

The top three preventable deaths for children ages fifteen to twenty four are motor vehicle, accidents, homicides and poisoning. The African American homicide rate is higher than that of whites in this age group. 83% of the 222 deaths due to homicide in this age group were African American. Possible prevention strategies include targeted activities in neighborhoods with high homicide rates, after-school recreation program, dropout prevention programs and alternative educational opportunities.

Through the Pennsylvania Child Death Review (CDR) program, the Bureau endeavors to understand how and why Pennsylvania children die. Deaths of children ages 21 and under are reviewed by multidisciplinary teams who seek to understand which of these deaths may have been preventable and to develop prevention strategies accordingly. This information is used for public health planning purposes and to inform policy discussions. Of the deaths reviewed in

2008, 23% were deemed preventable. Of the African American deaths reviewed, 54% occurred in children under the age of one. Sixty eight percent (68%) of the African American deaths reviewed were African American males.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	981	101	8
Children 1 through 4	149	14	0
Children 5 through 9	74	3	0
Children 10 through 14	100	8	0
Children 15 through 19	461	23	0
Children 20 through 24	811	31	0
Children 0 through 24	2576	180	8

Notes - 2011

Narrative:
Over 93% of deaths among infants and children aged 0 through 24 years were Non-Hispanic residents compared to 6.5% of Hispanic (which can be of any race) residents. Of the deaths reviewed as part of the CDR process, 8.4% were reported as Hispanic/Latino ethnicity. Sixty nine percent (69%) of the Hispanic/Latino deaths reviewed occurred in children under the age of one.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	3213676	2622685	434330	0	83358	0	0	73303	2008
Percent in household headed by single parent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	7.5	3.3	26.5	0.0	3.3	0.0	0.0	50.9	2009
Number enrolled in Medicaid	1150513	651842	316258	1752	24280	495	0	155886	2009

Number enrolled in SCHIP	211707	128903	29523	169	6807	121	3162	43022	2009
Number living in foster home care	15450	7303	6736	21	66	2	0	1322	2009
Number enrolled in food stamp program	801303	417642	258428	1205	10424	345	0	113259	2009
Number enrolled in WIC	392834	250001	102596	6221	9190	13119	11707	0	2009
Rate (per 100,000) of juvenile crime arrests	3424.4	2676.5	10928.2	0.0	825.6	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.3	1.6	4.6	3.4	1.4	0.0	3.4	0.0	2009

Notes - 2011
American Indian or Native Alaskan: Na
Native Hawaiian or other Pacific Islander included in Asian.
More than one race reported: Na
Source: PA State Data Center

Data are available only in a census year.

American Indian or Native Alaskan: Na
Native Hawaiian or Other Pacific Islander: Na
More than one race reported: Na
Percent in TANF (Grant) families is for FFY 2008-2009.
Source: PA Department of Public Welfare

More than one race reported: Na
Data are for FFY 2008-2009.
Source: PA Department of Public Welfare

Number enrolled in SCHIP – figures are as of 12/31/09.
Source: PA Department of Insurance

More than one race reported: Na
Data are for FFY 2008-2009.
Source: PA Department of Public Welfare

More than one race reported: Na
Other and Unknown: Na
Includes all enrolled in WIC (not limited to children 19 and under)
Source: Division of Women, Infants and Children

American Indian or Native Alaskan: Na
Native Hawaiian or Other Pacific Islander included in Asian.
More than one race reported: Na
Other and Unknown: Na

Rate (per 100,000) of juvenile crime arrests is based on population under age 18 and all arrests under age 18.
Source: Official PA State Police Web Site

Other and Unknown: Na
Percentage of high school drop-outs (grade 9 through 12) white and black are non-Hispanic white and black and Native Hawaiian or Other Pacific Islander is included in Asian. Data are for school year 2008-2009
Source: PA Department of Education

More than one race reported: Na
Number living in foster home care is as of 09/30/09. Children may be counted by more than one category of race.
Source: PA Department of Public Welfare

Narrative:
Based on estimates from the Pennsylvania State Data Center, there were 3,213,676 infants and adolescents 0 to 19 years old residing in Pennsylvania in 2008. Whites accounted for 81.6% of this population, Blacks for 13.5% and Asian/Pacific Islanders for 2.6%. Over seven percent of this population was enrolled in the Temporary Assistance for Needy Families program, which was consistent with the previous year (7.6%).

Although the estimated number of infants and adolescents 0 to 19 years old decreased by almost 12,000 from 2007 to 2008, enrollment figures for Medicaid, SCHIP, and the food stamp program increased for this population. However, the number living in foster home care, the rate of juvenile crime arrests, and the percentage of high school drop-outs decreased for this population.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	2970347	243329	0	2008
Percent in household headed by single parent	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	6.8	17.2	0.0	2009
Number enrolled in Medicaid	990952	159418	143	2009
Number enrolled in SCHIP	200189	11518	0	2009
Number living in foster home care	14110	1338	2	2009
Number enrolled in food stamp program	676372	124931	0	2009
Number enrolled in WIC	304112	72763	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	4654.1	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	5.9	0.0	2009

Notes - 2011
Ethnicity Not Reported: Na

Na

Ethnicity Not Reported: Na

Ethnicity Not Reported: Na

Ethnicity Not Reported: Na

Total NOT Hispanic or Latino: Na
Ethnicity Not Reported: Na

Total NOT Hispanic or Latino: Na
Ethnicity Not Reported: Na

Narrative:
For Hispanics, the percent of this population enrolled in the Temporary Assistance for Needy Families program decreased from the previous year. The Hispanic population followed the same pattern as the rest of this population for the enrollment figures for the various programs, and the rate of juvenile crime arrests and percentage of high school drop-outs.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	2852576
Living in rural areas	361100
Living in frontier areas	0
Total - all children 0 through 19	3213676

Notes - 2011
No standard definition provided for “metropolitan” area.

“Living in urban areas” is the number of children ages 0-19 in 2008 living in counties designated as urban (50% or more of the total population live in urban areas) in the 2000 U.S. Census.

“Living in rural areas” is the number of children ages 0-19 in 2008 living in counties designated as rural (less than 50% of total population live in urban areas) in the 2000 U.S. Census.

Na

Narrative:
In 2008, 88.8% of the childhood population less than 20 years of age resided in an urban area of the state, with the remaining 11.2% living in rural areas. These percentage estimates signify little change in the geographic distribution of the specified childhood population from the previous year.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	12011873.0
Percent Below: 50% of poverty	5.3
100% of poverty	12.1
200% of poverty	28.6

Notes - 2011

Narrative:
Based on data from the American Community Survey, an estimated 12.1% of the Pennsylvania household population had an annual income below the federal poverty level in 2008, compared to 13.2% nationally. Pennsylvania's data represents an increase from 2007 (11.6%). Population below 50% of the federal poverty level for Pennsylvania was 5.3%, compared to 5.6% nationally, and 28.6% below 200% of the federal poverty level, compared to 30.9% nationally. Figures for Pennsylvania remained essentially unchanged from 2007.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2717133.0
Percent Below: 50% of poverty	7.5
100% of poverty	16.8
200% of poverty	36.5

Notes - 2011

Narrative:
Based on data from the American Community Survey, an estimated 16.8% of the Pennsylvania household population under the age of 18 was below the federal poverty level in 2008, compared to 16.3% in 2007. This is below the national figure of 18.2%. Over 36% of this population was below 200% of the federal poverty level compared to 39.6% nationally and 7.5% were below 50% of the federal poverty level, compared to 7.8% nationally. Pennsylvania's figures remained essentially unchanged from 2007.

F. Other Program Activities

The Department is challenged with developing a statewide public health approach to the provision of genetic services. The opportunities and challenges posed by advances in human genetics on public health practice bring into focus the fact that much of public health training, infrastructure, policy, and program development have not taken genetics into consideration. The Department proposes to shift the current paradigm for delivery of genetic services from one of direct service to a more collaborative public health initiative that emphasizes prevention and integrates genetics into public health practices and policies. Future activities for genetics in public health will refocus to address modifiable risk factors for disease to help target preventive

interventions. The genetics program will work with other bureaus and programs within the Department to bring the genetics and public health communities together to more effectively educate professionals and the general public about the impact of genetic issues on the health of the general population, and to translate new knowledge of genetics into actions that will improve the public's health. During the fall of 2010, the Department will begin a RFA process to solicit applications to provide a public health approach to genetic services to residents within identified geographic regions and coordinate efforts with other regions to develop statewide comprehensive services for all Pennsylvania residents.

G. Technical Assistance

The NSFP requests technical assistance for data management. With the implementation of OZ eSP for reporting and follow up processes, the program is looking for use cases for data management. Program is interested in the use of other data tools useful to match resources with need (i.e.GIS mapping to look at clustering of conditions and geographic location of treatment).

Pennsylvania would like to establish a Birth Defects Surveillance Program. The Program would use data for services planning and evaluation, for development and evaluation of prevention strategies, to inform parents of children with birth defects about available services, for studies of the societal impact of birth defects, for referral of families to needed services and resources, and for clinical research studies. This Program would be a unique tool to benefit all related programs in the quest to improve the public's health. Technical Assistance is needed to establish goals and objectives for how data are to be collected, analyzed, disseminated and used.

As a Title V agency, transition activities for CYSHCN are funded, but only until a child reaches adulthood. At that time, the funding stream for CYSHCN is no longer applicable. However, programs are not responsive to the needs of young adults with behavioral, intellectual and physical disabilities if they do not have programs in place to accept them once they turn 21. An example is Medical Home. The Bureau funds a pediatric medical home program but that is not in effect once a child turns 21, nor is it appropriate or acceptable for a 21 year old young adult to be treated in a pediatric office. Training for adult medical homes for individuals with disabilities were funded by the Developmental Disabilities Council and that grant funding expired after 5 successful years. Technical assistance is needed to explore and identify mechanisms for expanding and implementing this type of training program under the auspice of Title V.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	24324168	24390794	24394001		24390794	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	63603000	61237809	64817000		63801000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	87927168	85628603	89211001		88191794	
8. Other Federal Funds *(Line10, Form 2)*	175932687	185295304	214426528		220257285	
9. Total *(Line11, Form 2)*	263859855	270923907	303637529		308449079	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2676486	2411995	2505486		2352733	
b. Infants < 1 year old	7810747	3991523	7648747		6937465	

c. Children 1 to 22 years old	48945267	47507334	46106401		45454277	
d. Children with Special Healthcare Needs	9466260	12501467	12667186		12500225	
e. Others	16984240	16901333	18087180		18542300	
f. Administration	2044168	2314951	2196001		2404794	
g. SUBTOTAL	87927168	85628603	89211001		88191794	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		158570		141713	
c. CISS	0		0		0	
d. Abstinence Education	0		1270677		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	170496864		205509204		212390947	
h. AIDS	0		0		0	
i. CDC	556441		690508		1331172	
j. Education	0		0		0	
k. Other						
1st Time Mother/NPI	0		250000		250000	
EPA	278348		278348		281453	
HUD	3000000		3875000		3945000	
MA Lead/NBS	0		1549000		1217000	
NBHS	341968		367664		150000	
St. Implem. CSHCN	0		0		300000	
Traumatic Brain Inj.	0		0		250000	
PRAMS	182422		177557		0	
State Implem. CSHCN	0		300000		0	
MA LEAD/NBS	882000		0		0	
TBI	100000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	23513175	22887045	24166375		24443921	
II. Enabling Services	2429017	3207896	2082255		1787639	
III. Population-Based Services	49043234	47201950	48667342		47479469	
IV. Infrastructure Building Services	12941742	12331712	14295029		14480765	
V. Federal-State	87927168	85628603	89211001		88191794	

Title V Block Grant Partnership Total						

A. Expenditures

Form 3 (State Maternal and Child Health Funding Profile), Form 4 (Budget Details by Types of Individuals Served and Sources of Other Federal Funds), and Form 5 (State Title V Program Budget and Expenditures) have been completed in accordance with the guidance.

B. Budget

3.3.1 Completion of Budget Forms

Form 2 (Maternal and Child Health Budget Details for FY 2011), Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served and Sources of Other Federal Funds), and Form 5 (State Title V Program Budget and Expenditures by Types of Service) have been completed.

3.3.2 Other Requirements

Pennsylvania's proposed budget for Federal Fiscal Year 2011 is in full compliance with the federally mandated "30%-30%" requirements. Of Pennsylvania's proposed federal grant award for 2011, $11,689,000 is designated for the support of preventive and primary services for children, and $10,297,000 is designated for the support of services for children with special health care needs. Following is a summary of the utilization of available funds.

Administrative Costs

Section 505 of the Maternal and Child Health Services Block Grant (MCHSBG) legislation limits the amount of the State's allocation that can be used for administration to not more than 10 percent. In FFY 2011, Pennsylvania plans to expend $2,404,794 or 9.86 percent for administration. The following is the definition of Administrative Costs used by the Pennsylvania Department of Health in administering the MCHSBG.

1. Personnel Costs
Personnel costs, including salaries and associated fringe benefits, are considered administrative if those costs are not incurred in the direct or indirect provision of prevention, education, intervention, or treatment services.

All personnel costs not included in this definition would be considered program and would not fall under the block grant administrative costs restriction.

2. Operational Costs
Operational costs are considered administrative if they are not required for the delivery of direct or indirect program services. Operational costs are considered program if they are utilized to support program-designated activities. The designations are by minor object of expenditure.

Maintenance of Effort Match

Section 505 of the MCHSBG legislation requires that a State receiving funds shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that the State provided for such programs in fiscal year 1989.

Pennsylvania bases maintenance of effort on a federal fiscal year, only including those state

appropriations which are solely used for MCH; i.e., 100 percent MCH-related. In Federal Fiscal Year 1989, Pennsylvania's maintenance of effort was $20,065,574.58, as detailed below in Table 2. For Federal Fiscal Year 2010, Pennsylvania's match will exceed the 1989 maintenance of effort level. The proposed expenditure of state Maintenance of Effort for 2011 is detailed below in Table 3.

Table 2
Maintenance of Effort (Match)
Federal Fiscal Year 1989

State Funded Appropriations Amount
108 School Health Services $17,265,914.86
112 Maternal and Child Health $1,661,120.00
120 Sickle Cell Summer Camps $35,000.00
137 Tourette Syndrome $100,000.00
164 Home Ventilators $1,003,539.72
TOTAL $20,065,574.58

Table 3
Planned Maintenance of Effort (Match)
Federal Fiscal Year 2011

State Funded Appropriations Amount
108 (10654) School Health Services $37,620,000.00
112 (10651) Maternal and Child Health $2,448,000.00
TOTAL $40,068,000.00

Note: Consistently, since 1989, the BFH has used a constant set of appropriations to indicate our maintenance of effort match.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.